Welcome!

We would like to thank you for choosing Little Discoveries Learning Center and ensure you that we have a commitment to all parents and children enrolled in our Center. As part of the enrollment process, we are required to acquire additional information regarding your child and family.

If you have any questions regarding this information, please feel free to ask the Director.

Please make sure all forms are filled out completely and legibly.

Registration Forms include:

- Child information
- Parent / Guardian Information
- Emergency Contact & Authorized Persons
- Parent Permission Agreement
- Healthcare Summary *(Form **MUST** be signed by a physician)*
- Immunization Form *(A copy of your child's records and parent / guardian signature)*
- Child Emergency Information Card
- Tuition Payment Form *(Checking / Savings or Credit Care option)*
- Tadpoles Letter *(Parent App)*
- Child Social Resume

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Registration Forms

For Office Use:

Date of Enrollment: _____
Official Start Date: _____
Classroom: _____
Director Initials: _____

Child Information

First Name: _____ **Middle Name:** _____ **Last Name:** _____

Name your child prefers to be called: _____ **Date of Birth:** _____

Gender: [ ] Male [ ] Female **Child's Address:** _____

Child's Typical Weekly Schedule: The schedule you provide will be used weekly unless given other notification.

(Reminder a child may only be at the Center 10 hours max a day)

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Medical Information:

Pediatrician's Name: _____ Clinic/Hospital: _____

Phone: _____ Address: _____

Dentist Name: _____ Office Name: _____

Phone: _____ Address: _____

Does your child have any special requirements for:

Diet: [ ] Yes [ ] No *Details:* _____

Allergies [ ] Yes [ ] No *Details:* _____

Behavior [ ] Yes [ ] No *Details:* _____

Medical [ ] Yes [ ] No *Details:* _____

Is your child under a Professional?

Speech and Language Therapist	[ ] Yes [ ] No	Physiotherapist	[ ] Yes [ ] No
Occupational Therapist	[ ] Yes [ ] No	Consultant Pediatrician	[ ] Yes [ ] No
Social Care	[ ] Yes [ ] No	Health Visitor	[ ] Yes [ ] No

Please list professionals involved with your child:

Agency Name: _____ Name: _____ Phone: _____

Agency Name: _____ Name: _____ Phone: _____

Agency Name: _____ Name: _____ Phone: _____

Do you have any worries or concerns about your child? [ ] Yes [ ] No

Details: _____

_____

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Parent/Guardian Information

Mother/Guardian Information:

First Name: _____ **Middle I:** _____ **Last Name:** _____

Address: _____

Date of Birth: _____ **Email Address:** _____

Home Phone: _____ **Cell Phone:** _____

Relationship to Child: _____

Occupation: _____ **Work Phone:** _____

Work Address: _____ **Work Hours:** _____

Father/Guardian Information:

First Name: _____ **Middle I:** _____ **Last Name:** _____

Address: _____

Date of Birth: _____ **Email Address:** _____

Home Phone: _____ **Cell Phone:** _____

Relationship to Child: _____

Occupation: _____ **Work Phone:** _____

Work Address: _____ **Work Hours:** _____

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed

Child's Primary Residence: [ ] Both [ ] Mother [ ] Father

If divorced, who has legal custody? [ ] Joint [ ] Mother [ ] Father

Were you referred to our program? [ ] Yes [ ] No

If yes, please provide the family name: _____

For Office Use:

Parent/Guardian 1:
Keyless Entry Pin: _____
Procare User ID: _____
Procare Password: _____

Parent/Guardian 2:
Keyless Entry Pin: _____
Procare User ID: _____
Procare Password: _____

Emergency Contacts & Authorized Pickup Persons:

Please list at **least two people** other than Parent/Guardian that we would be able to contact if we are unable to get ahold of the Parent/Guardian in case of illness or emergency.
Please list any others that you authorize to pick up your child. If the person picking up your child is NOT listed on this form, you must notify the Director in writing in advance. Photo ID will be required of any person pick up your child.

1st Contact

Name: _____ Phone: _____

Relationship to the Child: _____ Address: _____

Authorized Pickup [ ] Yes [ ] No

Emergency Contact [ ] Yes [ ] No

2nd Contact

Name: _____ Phone: _____

Relationship to the Child: _____ Address: _____

Authorized Pickup [ ] Yes [ ] No

Emergency Contact [ ] Yes [ ] No

3rd Contact

Name: _____ Phone: _____

Relationship to the Child: _____ Address: _____

Authorized Pickup [ ] Yes [ ] No

Emergency Contact [ ] Yes [ ] No

4th Contact

Name: _____ Phone: _____

Relationship to the Child: _____ Address: _____

Authorized Pickup [ ] Yes [ ] No

Emergency Contact [ ] Yes [ ] No

5th Contact

Name: _____ Phone: _____

Relationship to the Child: _____ Address: _____

Authorized Pickup [ ] Yes [ ] No

Emergency Contact [ ] Yes [ ] No

Parent Permission Agreement

I hereby give permission for the Little Discoveries Learning Center Staff to provide simple first aid treatment to my child, when necessary. In the event of a more serious illness or injury, I give permission for my child to be transported to a hospital or other emergency medical facility to receive emergency medical treatment. I also authorize ambulance/rescue squad attendants to administer such treatment as is medically necessary, and I authorize licensed health practitioners working in the hospital or emergency medical facility to examine and provide emergency medical treatment to my child if warranted. I understand that I will be contacted by child care program personnel as soon as possible regarding any emergency involving my child.

Please check the following:

- o I understand that any medical or health expenses will be the responsibility of my own self.
- o I understand that it is Little Discoveries Learning Center's policy that my child will be immunized according to the schedule provided by Minnesota Department of Health.
- o I hereby give permission to photograph and maintain photos of my child within the Center.
- o I hereby give permission to photograph my child and use photos on social media outlets (ex: Facebook, website, etc.)
- o I hereby give permission to have my child's records be viewed by center management, MN State Licensors, and local health consultants.
- o I hereby give permission for my child to use all the play equipment and participate in all the activities at Little Discoveries Learning Center.
- o I hereby give permission for my child to leave the building under supervision with a staff member for walks, outdoor activities, and for field trips in an authorized vehicle.
- o I understand that Little Discoveries Learning Center is not responsible for my child who has not been signed in, nor is responsible after my child has been signed out. For school age children, Little Discoveries Learning Center will be responsible for my child once they enter the building after getting dropped off from the bussing transportation.
- o I have read the Little Discoveries Learning Center's Parent Handbook. I understand and agree that it is my responsibility to read and familiarize myself with the policies and procedures. I understand that it is my responsibility to address any questions I may have with the Site Director.

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

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Child Emergency Information Card

First Name: _____ **Middle Name:** _____ **Last Name:** _____

Date of Birth: _____ **Child's Address:** _____

1st Parent / Guardian Contact Information:

Relationship to Child: _____

Name: _____

Address: _____

Email Address: _____

1st Phone Number: _____

2nd Phone Number: _____

Employer: _____

2nd Parent / Guardian Contact Information:

Relationship to Child: _____

Name: _____

Address: _____

Email Address: _____

1st Phone Number: _____

2nd Phone Number: _____

Employer: _____

Emergency Contacts *(other than parents)*

Name: _____ Phone: _____

Relationship to the Child: _____ Address: _____

Name: _____ Phone: _____

Relationship to the Child: _____ Address: _____

Authorized Person to pick up child:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Person(s) NOT authorized to pick up my child:

Name(s):

_____

Allergies or Medical Information:

_____

HEALTH CARE SUMMARY

MUST BE COMPLETED BY HEALTH CARE SOURCE

Date of Enrollment: _____

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 _____

_____

_____

Phone _____

Signature of Health Source _____ Address _____

Date _____ _____

MS-2083

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 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: _____

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)

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Tuition Checking / Savings Authorization Form

I (we) hereby authorize Little Discoveries Learning Center to initiate debit entries to my (our) checking or savings account, indicated below. This authority will remain in effect until I (we) give a 21 days' written notice to cancel it. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Please check one of the options below for your tuition payments.

☐ **Checking Account 2 - Week Cycle**

☐ **Checking Account 4 - Week Cycle**

OR

☐ **Savings Account 2 - Week Cycle**

☐ **Savings Account 4 - Week Cycle**

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

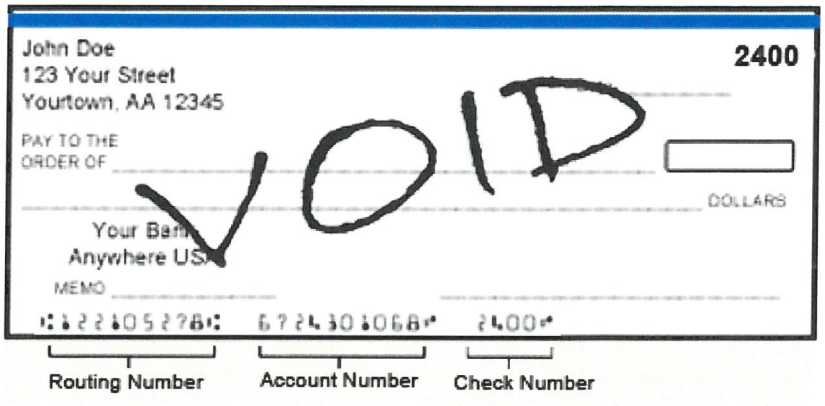
Routing Transit Number *(see sample below)* _____ Account Number *(see sample below)* _____

Authorized Signature _____ Date _____

For Office Use:

Date Received: _____

Director Signature _____



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Tuition Credit Card Authorization Form

I (we) hereby authorize Little Discoveries Learning Center to initiate fee charges to my (our)credit card account, indicated below. This authority will remain in effect until I (we) give a 21 days' written notice to cancel it. I (we) acknowledge the service fee that will be applied to my (our) account.

Please check one of the options below for your tuition payments.

☐ **Credit Card 2 - Week Cycle**
(A $10 service fee will be added to my account)

☐ **Credit Card 4 - Week Cycle**
(A $20 service fee will be added to my account)

Credit Card Information	
Card Type: o MasterCard o Visa	
Cardholder Name *(as shown on card)*	
Card Number	
3 Digit Code	Expiration Date *(mm / yy)*
Cardholder Billing Address	
Authorized Signature	Date

Office Use Only

Director Signature _____

Date Received _____

tadpoles

Dear Families,

Keeping you involved with Little Discoveries and your child's daily experiences has always been a priority of ours. We are very excited to announce that we are rolling out a program called **Tadpoles**!

From Tadpoles, teachers can send photos and videos to allow you to see a glimpse into your child's day! Teachers will also be creating a daily report for each child. This daily report will keep you informed of the daily activities, learning experiences, and care events for your child each day. All photos, videos, and daily reports are emailed to you directly and you can also access them via the **free** Tadpoles Parent app, available on Apple and Android devices, or online at www.tadpoles.com as well!

To create your account: Download the App on your phone.
Please use the following steps:

- Visit your App store
- Search Tadpoles Parent, then download
- Create a login email
    - You MUST use the email address that is currently on file for the Center (on your procare account)
        - If it's a Gmail account, you can sign right in to the account
        - If it's not a Gmail account, enter your email, choose to submit and check your email for the link to establish your password.

Tadpoles will continue to strengthen our home-to-school connection. From your Tadpoles parent account, via the app or web, you will be able to enter in morning drop off notes for your child's teachers, mark your child absent, and/or add any additional notes to be communicated to the school.

Each classroom will be equipped with an iPad - which will be specifically used for the Tadpoles program. If you see a teacher on what looks like a phone or tablet, rest assured, they are only using the device to input information into Tadpoles. The devices are locked down, giving teachers access to only the Tadpoles software.

We consider all information captured within Tadpoles to be a private communication between our school and our families. No personal information is shared with any external parties and as a parent you will only receive information specifically about your child. The confidentiality of all information is maintained through the security features of the Tadpoles software.

We are very excited to begin utilizing Tadpoles and know it will positively impact the engagement of our families and our home-to-school connection. We feel confident that you will love Tadpoles and the level of involvement it allows you to have with your child's daily experiences while at Little Discoveries! We are happy to answer any questions or concerns you may have about this exciting program!

Thank you!
Little Discoveries Team