# Enrollment Form

Parent's/Guardian's Name:______________________________________________

Child's Full Name:____________________________________________________

Child's Age:_______________________Date of Birth:____________________

Street Address:_______________________________________________________

City:________________________State:________________Zip Code:___________

Home Phone Number:___________________________________________________

Emergency Beeper/Cell Number:__________________________________________

Father's Place of Business:_____________________________Phone:____________

Mother's Place of Business:____________________________Phone:____________

Guardian's Place of Business:___________________________Phone: ___________

Driver's License Number: State______________ Number_______________________

Child's Pediatrician:__________________________________Phone:____________

Name of Medical Insurance:____________________________________________

Insurance Policy Number:______________________________________________

Policy Holder's Name:_________________________________________________

Allergies to Food(s):_________________Allergies to Medication(s): _________________

Name of people Authorized to pick your child up from daycare when you are not able to:

1. ___________________________Address:______________________________
   Phone Number:_________________Relation:____________________________
2. ___________________________Address:______________________________
   Phone Number:_________________Relation:____________________________
3. ___________________________Relation:_____________________________

| Office Use Only |
| --- |
| Start Date:______________________ |
| Disenrollment Date:______________ |

# PARENT AUTHORIZATION FOR EMERGENCY TREATMENT

In consideration of admittance, I hereby authorize Family Tree to arrange for medical examination and/or treatment of my child_________________________________should an emergency arise at the daycare center or on a field trip. It is understood that a conscientious effort will be made by the day care provider to contact me at the emergency numbers I have provided.

I would prefer to have my child transported to the following hospital if the need arises.

(Hospital)______________________________. I understand that the choice of hospital may be limited by service of the local rescue squad.

| ____________________________ | _________________ | ____________________ |
|---|---|---|
| Signature Mother/Guardian | Home/Cell Phone | Business Phone |
| ____________________________ | ___________________ | ____________________ |
| Signature Father/Guardian | Home/Cell Phone | Business Phone |

Insurance Company_________________________________________________________________

Policy Number

_____________________________________________________________________

Relatives or other persons to be contacted in an emergency:

| | |
|---|---|
| Name_____________________________ | Name________________________________ |
| Address___________________________ | Address______________________________ |
| __________________________________ | ___________________________________ |
| Phone_____________________________ | Phone________________________________ |
| Relationship to Child_________________ | Relationship to Child_____________________ |

# ADMINISTRATING MEDICATION IN DAYCARE

A Family Tree

**A daycare child who must take medication during the day care hours is required to have a medication request completed and returned to the daycare provider. New requests must be filled out by the parent/guardian each time medication is to be administered.**

**Medication will be dispensed by the daycare provider. The medication will be maintained in a secure place.**

**Both prescription and non- prescription medication must be in a labeled container with the following information:**

***CHILD'S NAME * PRESCRIBING PHYSICIANS NAME * NAME OF MEDICATION***

*** DOSAGE AND STRENGTH OF MEDICATION * DATE, AMOUNT AND TIME TO BE**

**ADMINISTERED * NAME AND SIGNATURE OF PERSON ADMINISTERING**

**MEDICATION**

Various medication ***MUST NOT*** be combined in the same container.

**Medication Form**

Name of Child______________________________________________________________

Name of Prescribing Physician ______________________________________________

Phone Number ____________________Name of Medication_______________________

Strength of Medication______________________________________________________

Dosage and Time to be Administered__________________________________________

Period of Administration____________________________ to ______________________

Possible Side Effects_________________________________________________________

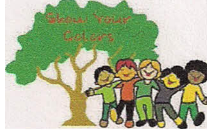
I hereby give permission for Family Tree to administer the above named medication to my child.

Signature of Parent/Guardian________________________________________Date_____________

Name of person administering medication:_____________________________________

Signature of person administering medication:__________________________________

# TYLENOL RELEASE FROM



A FAMILY TREE

Dear Family Tree Parents:

As your child's caregivers, we would like very much to keep them comfortable and safe at all times. In the event of fever, we would like to administer Tylenol as soon as needed. If you are agreeable, please fill out the form below and return to us a bottle of Tylenol labeled with your child's name as soon as possible. We will notify you that the Tylenol has been administered and inform you of other symptoms.

Sincerely,

A Family Tree

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Date_____/_____/______

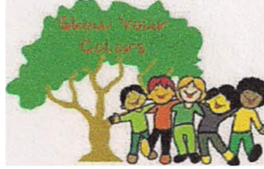
Child's Name_____________________________________________ Age_______ Weight _______________

Appropriate Dose__________________________________

I give A Family Tree permission to administer Tylenol in the event of a fever.

Parent/Guardian Signature___________________________________________________________________

# Photo Release Form




A Family Tree

Family Tree is proud to be part of many community service projects in our state. We often send press releases to local newspaper and TV stations with that we take photos of children participating at such events.

I give permission for my child ________________________________________to be photographed or videotaped while involved in activities connected with the enrichment program at 2356 West Shore rd, Warwick, RI No commercial use will be made of these photographs or videotape without further consent.

Photo Release Form

Name of Child___________________________________________________________________________

Name of Parent__________________________________________________________________________

Age of Child_____________________________________________________________________________

Address_________________________________________________________________________________

Photo Release: I herby give Family Tree the absolute irrevocable right and permission, under the below terms for use of photography's/video/film taken during any program activities. I herby forever release and discharge Family Tree, their heirs, affiliated companies, officers, directors, managers, employees, legal representatives, agents assigns, and third party for whom said photographs/video/film were taken, from any and all claims, actions depends arising out of or in connection with use of said photographs/video/films including without limitation, any and all claims for invasion of privacy and libel. Consent must be given by Parent/Guardian of said child named above.

Parent/Guardian_______________________________________________Date______________________

Travel and Activity Authorization for Family Tree Enrichment Program

I give my child_____________________________________________permission to leave the neighborhood walks or field trips in an authorized vehicle.

Parent/Guardian ______________________________________________Date________________________

School Name & Address:

# STATE OF RHODE ISLAND
# SCHOOL PHYSICAL FORM

Health Care Provider Name and Address:

Phone:

This form may substitute for any district-issued form. All districts must accept this form. General health examinations shall be documented in a standardized format with one copy available from the Rhode Island Department of Health or in any such format that captures the same fields of information (R16-21SCHO Section 8.4)

| Student Name: Last | First | Middle | Date of Birth | Sex |
|---|---|---|---|---|
| | | | | |

| Address: Street | Apt # | City | State | Zip Code | Home Phone |
|---|---|---|---|---|---|
| | | | | | |

PLEASE COMPLETE ALL INFORMATION BELOW (May attach immunization transcript).

| IMMUNIZATIONS | Please enter dates in MM/DD/YYYY format | | | | |
|---|---|---|---|---|---|
| Hepatitis B | | | | | |
| Diphtheria-Tetanus-Pertussis DTP/DTaP | Check ☐ if DT | Check ☐ if DT | Check ☐ if DT | Check ☐ if DT | Check ☐ if DT |
| Pneumococcal Conjugate PCV | | | | | |
| Polio | | | | | |
| Haemophilus Influenzae Type B Hib | | | | | |
| Measles-Mumps-Rubella MMR | | | | | |
| Varicella | | | ☐ Student has history of varicella disease | | |
| Tetanus-Diphtheria-Pertussis TdaP/Td | Check ☐ if Td | Check ☐ if Td | Check ☐ if Td | | |
| Rotavirus | | | | | |
| Hepatitis A | | | | | |
| Meningococcal | | | | | |
| HPV | | | | | |

Immunization Exemption: ☐ Medical ☐ Religious

☐ Hep B ☐ DTaP ☐ PCV ☐ Polio ☐ Hib ☐ MMR ☐ Varicella ☐ Td/Tdap ☐ Rotavirus ☐ Hep A ☐ Mening ☐ HPV

PHYSICAL EXAMINATION

Date of PE _____/_____/_____ Height ___________ Weight___________ BP____________

Please note any health problem, chronic health condition or disability that may affect behavior or health at school:

ASTHMA: No ☐ Yes ☐ DIABETES: No ☐ Yes ☐ OTHER: ___________________________________

Significant Systems Findings: ___________________________________

ALLERGIES: No ☐ Yes ☐ (Please explain) ______________________EPINEPHRINE AUTO-INJECTOR REQUIRED: No ☐ Yes ☐

Treatment Plan: ___________________________________

MEDICATION (REQUIRED AT SCHOOL): No ☐ Yes ☐ (Please list) ___________________________________

Other medication(s) that may affect behavior or health at school: ___________________________________

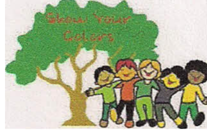
RESTRICTIONS: Can participate in physical education: Fully☐ With limitation ☐ ______________________

Can participate in sports: Fully☐ With limitation ☐ ______________________

| LEAD SCREENING (Required for children < 6 years of age only)<br>Student is in compliance with lead screening requirements:<br>Yes ☐ No ☐ | SCOLIOSIS SCREENING<br>Yes ☐ No ☐ | | VISION SCREENING (Children entering Kindergarten)<br>☐ Passed screening<br>☐ Screened and referred for comprehensive exam<br>☐ Referred for comprehensive exam, but not screened<br>Screening Date: Comprehensive Exam Date: |
|---|---|---|---|
| TUBERCULOSIS (If required by school district)<br>Date of TB test: | | | |

HEALTH CARE PROVIDER SIGNATURE: ___________________________________ DATE: ______________________

PRINT NAME: ___________________________________



A FAMILY TREE

**HEALTH FORM #2**

**All children on a child care or enrichment program in Rhode Island must have a completed Physician's record of Immunization and Pre Admission Examination be provided to the program Director. In addition to completing the Health form #1 please have your physician return this form to our program at one of the following locations:**

**2339 West Shore Rd Warwick, RI** **126 Edythe Street Warwick, RI**

**1648 Warwick Ave Warwick RI** **690 Dyer Ave Cranston, RI**

**Child's Name**_________________________________________________________________

**Has your child had a Tuberculin Skin test?** **Yes**________ **No** __________

**If yes, Indicate: Date**_____________ **Positive:** ____________ **Negative:** ____________

**Has your child had a Lead Screening test?** **Yes**________ **No** _________

**If yes, Indicate: Date**_____________ **Positive:** ____________ **Negative:** ____________

**Has your child ever visited a dentist or dental clinic?** **Yes**_______ **No**__________

**Date:** _______________

**Parent/Guardian Signature:**__________________________________________

# MEAL BENEFIT FORM for Child Care

Discharge Date: _______

## Part 1. Children in Day Care

| Names of all children in care (First, Middle Initial, Last) | √ if Foster Child | √ if Homeless, Migrant or Runaway |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

If any member of your household receives Supplemental Nutrition Assistance Program (SNAP) or RIWorks, provide the name and full case number for the person who receives benefits.

NAME: ____________________________

CASE #: __ __ __ - __ __ - __ __ __ __

If no one receives these benefits, skip to Part 2.

## Part 2. Total Household Gross Income

### You must tell us how much and how often

| 1. **Name** (List everyone in household, including foster children) | 2. **Gross income and how often it was received** *Examples: $250/monthly $400/twice a month $125 every other week 190/weekly* | | | | 3. Check if **NO** income |
|---|---|---|---|---|---|
| | Earnings from work before deductions | Welfare, Alimony, Child Support | Pensions, Retirement, social security | Other | |
| 1. | | | | | □ |
| 2. | | | | | □ |
| 3. | | | | | □ |
| 4. | | | | | □ |
| 5. | | | | | □ |
| 6. | | | | | □ |
| 7. | | | | | □ |
| 8. | | | | | □ |
| 9. | | | | | □ |

## Part 3. Signature and Social Security Number (Adult must sign)

An adult household member must sign the application. If Part 2 is completed, the adult signing the form must also list the last four numbers of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this form.)

*I certify (promise) that all information on this application is true and that all income is reported. I understand that the childcare program will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, I may be prosecuted.*

Sign here: ______________________________________________ Date: ___________

Social Security Number (last 4 numbers only): * * * - * * - __ __ __ __ □ I do not have a Social Security Number

## Part 4. Children's racial and ethnic identities (optional)

Choose one ethnicity:

□ Hispanic or Latino □ Not Hispanic or Latino

Choose one or more (regardless of ethnicity):

□ Asian □ Black or African American □ American Indian or Alaskan Native □ Native Hawaiian or Other Pacific Islander □ White

## Don't fill out this part. This is for official use only.

***Income Conversion: Weekly X 52, Every 2 Weeks (bi-weekly) X 26, Twice A Month X 24, Monthly X 12***

Total Income: _________ Per: □ Week, □ Every 2 weeks, □ Twice a Month, □ Month, □ Year

Household size: _______ Categorical Eligibility: SNAP/RIWorks ___ Foster Child: _____ Homeless ___ Migrant ___ Runaway ___

Eligibility: Free ____ Reduced ____ Denied ____ Reason: ________________________

Determining Official's Signature: _________________________________ Approval Date: ___________

# Instructions for Completing Meal Benefit Form

**Foster children are eligible for free meals regardless of household income. If all the children you are applying for are foster children, follow these instructions:**

Part 1: List all foster children enrolled in care. Check the box indicating the child is legally recognized as a foster child.
Part 2: Skip this part.
Part 3: Sign the form. The last four digits of a Social Security Number are not necessary.
Part 4: Answer this question if you choose to.
If some of the children in the household are foster children and others are not, follow the instructions for "ALL OTHER HOUSEHOLDS".

**If your household gets SNAP OR RIWorks benefits, follow these instructions:**

Part 1: List each child's name. Indicate the name and SNAP or RIWorks case number of a household member.
Part 2: Skip this part.
Part 3: Sign the form. A Social Security Number is not necessary.
Part 4: Answer this question if you choose to.

**ALL OTHER HOUSEHOLDS, follow these instructions (include all foster children in addition to family members):**

**Part 1**: List each child's name attending this day care center. Check off if child is a foster child, homeless, migrant or runaway. If any household member receives SNAP or RIWorks benefits, list name and full case number.

**Part 2**: Follow these instructions to report total household income from last month.

**Column 1- Name:** List the first and last name of **each** person living in your household, related or not (such as grandparents, foster children, other relatives, or friends). You must include yourself. Attach another sheet of paper if you need to.

**Column 2- Gross income and how often it was received:** For each household member, list each type of income received for the month. You must tell us how often the money is received—weekly, every other week, twice a month or monthly. For earnings, be sure to list the **gross income**.,.not the take home pay. **Gross income is the amount earned before taxes and deductions.** It should be listed on your pay stub, or your boss can tell you. For other income, list the amount each person got for the month from welfare, child support, alimony, pensions, retirement, Social Security, Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits, regular contributions from people who do not live in your household, and ANY OTHER INCOME. Report net income for self-owned business, farm, or rental income. Next to the amount, write how often the person got it. If you are in the Military Privatized Housing Initiative or get combat pay, do not include these allowances as income.

**Column 3- Check if no income:** If the person does not have any income, check the box.

**Part 3**: An adult household member must sign the form and list the last four numbers of his/her Social Security Number, or mark the box indicated if he or she doesn't have one.

**Part 4**: Answer this question if you choose to. We request this information solely for the purpose of determining compliance with Federal civil rights laws, and your response will not affect consideration of your application.

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**Privacy Statement Act: This explains how we will use the information you give us.** The Richard E. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your children for free or reduced price meals (if the daycare program has a separate charge for meals) or the day care center may not receive maximum federal funds for providing a meal program (if the daycare program provides meals at no charge). The Social Security Number is not required when you apply on behalf of a foster child or you list a SNAP or RIWorks case number or if the person signing the form indicates that they do not have a Social Security Number. We WILL use your information to see if your children are eligible for free or reduced price meals, to run the program, and to enforce the rules of the program. .

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**Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.** **Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.** The U.S Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form found online at http://www.ascr.usda.gov/complaint_filing_cust.html or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

USDA is an equal opportunity provider and employer.

Further, the Rhode Island Department of Education does not discriminate on the basis of sexual orientation or religion. To file a complaint of discrimination with the State of Rhode Island, write to the Rhode Island Department of Education, Director, Office of Equity and Access, 255 Westminster Street, Providence, RI or call (401) 222-4600.

**Need low or no cost health insurance for your children? Call RiteCare at 462-5300 (462-3363 TTY) or www.dhs.ri.gov**

# Meal Benefit Form Page Two

## Required Enrollment Information

This form must be signed by a parent or guardian and must be updated annually.

**Name of child**:________________________________

| | Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|---|
| **Normal hours in care:** | | | | | |
| **Breakfast** | | | | | |
| **AM Snack** | | | | | |
| **PM Snack** | | | | | |

Signature of Parent/Guardian:________________________________________________________

Date:________________________________________

## USDA Nondiscrimination Statement

Last Modified: 10/23/2014

The U.S. Department of Agriculture (USDA) prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal and, where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email atprogram.intake@usda.gov.
Individuals who are deaf, hard of hearing, or have speech disabilities and wish to file either an EEO or program complaint please contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (in Spanish).

Persons with disabilities, who wish to file a program complaint, please see information above on how to contact us by mail directly or by email. If you require alternative means of communication for program information (e.g., Braille, large print, audiotape, etc.) please contact USDA's TARGET Center at (202) 720-2600 (voice and TDD).USDA is an equal opportunity provider and employer.

**This form collects information about children in order to aid our child care workers in individualizing the program of care for your child. Please complete the information below.**

**Health:** Please note any health conditions that may affect the care of your child.
Child has frequent colds: ______yes ______no, Ear infections: _____yes _____no
If "yes", please describe:____________________________________________
Any other information we should know about the health and/or development of your child:____yes_____no, If "yes", please describe:____________________________________________
____________________________________________

**Meals:** Current feeding schedule: ___________Length of time on current schedule:_________
Does your child use a ____ spoon,____ fork,____ hands _____ cup; Milk Type:__________________
Does your child have any food allergies:____________________________________________
Favorite Foods:____________________________________________
Refused Foods:____________________________________________

**Sleep:** Current sleep schedule:___________________ Length of time on current schedule:__________________
Falls asleep easily_____ yes, _____no; Mood upon awakening – Describe__________________
Takes favorite toy(s) to bed: _____yes, _____no, if "yes", list toy(s):__________________
Sleep Position: _____back, _____side _____ stomach

**Diapering/Toileting**: Highly sensitive skin: _____ yes _____no, Frequent diaper rash: _____yes _____no,
Lotions, powders or salves used: _____yes _____ no, if "yes" product name:__________________
Toilet training attempted: _____ yes _____no, if "yes" describe routine:__________________
Type of toilet seat used at home:__________________, Regular bowel movements:_____ yes _____ no
Time(s) of day:__________________, Toileting problems: _____yes _____ no
If "yes: describe:____________________________________________

**Verbal Communication**: Family speaks what language(s) at home: __________________
Age child began talking:___________, Child speaks in ______ words _______sentences
Words used to describe special desires– specify: __________________
____________________________________________

**Comforting:** Does your child have a fussy time ______ yes__ ___ no, if "yes" what time:__________________
How is fussy time handled:____________________________________________
Child likes to be _______ held _______sung to _______ rocked _______read to _____other_____ what
Special things you say or do to comfort child:__________________
____________________________________________

**Self Expression:** What causes your child to feel angry or frustrated?__________________
____________________________________________
What frightens your child and how is it shown? __________________
____________________________________________
How does your child express feelings of happiness, enjoyment, etc.?__________________
____________________________________________

**Physical and Social Development**: Is your child use to playmates: _____yes _____no

**Miscellaneous:** Child's **indoor** favorite toys and activities – specify:____________________________

Child's **outdoor** favorite toys and activities – specify:____________________________

By providing complete information about your child, you will be assisting staff in creating a positive experience for him/her while in our care. List any information about your child's habits, abilities or personality that you feel will be helpful to the staff while caring for your child:

____________________________ ____________________

**SIGNATURE** – Parent or Guardian Date Signed

# RESOURCES

Association for Childhood Education International 1-800-423-3563

Bradley Hospital, Support and education for teachers and families caring for children with mental illness. (401) 432-1000

CHILDSPAN, WWW.CHILDSPAN.NET (401) 729-0765

Family Child Care Homes of Rhode Island Continuing Education Workshops (401) 353-7645

Family Solutions CEDARR, support for families caring for children with serious emotional disturbances, serious health problems, autism or developmental disabilities. (401) 461-4351 or 1-800640-7283

Friends Way, Grief Support for Children, Teens and Families (401)884-0200

Mental Health Association of Rhode Island (401) 726-2285

Office of the Child Advocate, Lareen D'Ambra (401) 222-6650

Educational Surrogate Parent Program (401) 222-4792

Prevent Child Abuse Rhode Island (401) 728-7920

Providence Public Library, LARK- Learning and Reading Kits (401) 455-8000

www.provlib.org

RI Parent Information Network www.ripin.org 1-800-464-3399

The Rhode Island Association of young Children www.naeyc.org

United Cerebral Palsy of Rhode Island (401) 941-9937

Woman's Center of Rhode Island Safety and Support to adults and children who are experiencing abuse Business (401) 861-2761, Helpline (401) 861-2760

Youth Pride Inc. Providers to RI area youth affected by sexual orientation and gender identity (401) 421-5626