

**Sharon Day Care Center
Child Schedule & Registration
2017-2018**

We as parents or guardians, hereby register our child, _____ at the Sharon Day Care Center, according to the schedule found below. We understand that we are responsible for the full day rate of \$40.00 and/or the half day rate of \$25.00 in the Preschool Program, and/or the full day rate of \$55.00 and/or the half day rate of \$40.00, in the Infant and Toddler program. We will be billed and will pay for services provided on a weekly basis. We understand that there is a minimum enrollment of 2 days per week and agree to pay this amount. Every child will receive "personal" day(s) equivalent to his/her weekly schedule. For example, if your child attends the center three (3) days a week, he/she will receive three (3) days per school year (September-June) to use for sick/vacation/personal days with no charge. Please let the center director, Carrie Olsen, know when using these days. Any financial assistance obtained or granted will be credited on receipt of funds. The annual registration fee, of \$50.00 per child, \$75.00 for two or more children, will be billed within the first week of September and is used for curriculum items and enrichment activities. It is non-refundable.

Please fill in the regular hours you are planning on your child attending each week, next to the days provided (school hours are 7:30 AM to 5:30 PM):

Monday	
Tuesday	
Wednesday	
Thursday	
Friday	

Start Date: _____

Child's birthdate _____

Signature of Parent/Guardian: _____ Date: __/__/__

Signature of Parent/Guardian: _____ Date: __/__/__

Signature of Director: _____ Date: __/__/__

We hope that that your child will also attend the center whenever there is a need, as long as we have a week's notice, as schedule changes affect staffing and curriculum materials.

It is a pleasure to enroll your child and we are grateful for your support! The teachers join me in welcoming you to our center!

Best,

Carrie-Ann Olsen-Director



P.O. Box 1031 · Sharon, CT 06069 · (860) 364-5182

Developmental History and Background Information:

Child's Name: _____ Date of Birth: _____

Person completing: _____ Relationship to child: _____

Date Completed: _____

Please tell us about your child:

1. How would you like to receive communications from the Center such as newsletter, updates? Email: _____ Center Mail _____
2. Describe your child's daily schedule: bedtime, naptime, feeding/eating etc: _____

3. Does your child feed himself/herself? _____ Drink from a cup? _____
4. What foods does your child like to eat? _____
5. Does your child have any food restrictions? (ex dairy) _____
6. Does your child have a special diet? (ex vegetarian) _____
7. Does your child have any known food allergies: _____
8. What is your child's bathroom routine? _____
9. What does your child call going to the bathroom? (ex.-potty) _____
10. Are you in the process of toilet training? _____
11. How does your child tell you that he/she needs to use the bathroom? _____
12. Does your child need help, verbal prompting, or reminders about going to the bathroom? _____
13. How does your child like to be comforted? _____
14. Does your child have any particular fears? (thunder, dogs, loud noises, the dark, etc.) _____
15. What is your child's favorite activity? _____
16. What is your child's favorite song? _____
17. What is your child's favorite book? _____
18. If applicable, how do you handle behavior difficulties at home? _____
19. Please list any previous child care/schooling experiences your child has had _____
20. What experiences or skills do you hope your child will gain at this center?

21. What Holidays do you celebrate?(if any)_____
-
22. Does your child nap at home?_____ For how long?_____
23. ****For Infants only**** How many naps would you like your child to take? At what times?_____
-
24. What does your child nap with? (please provide these items for rest time)_____
-
25. What routine do you perform at home before putting your child to sleep? (ex.,rocking, singing, reading,etc.)_____
-
26. Does your child enjoy looking at books?_____
27. Do you have children's books available in the child's home language?_____
28. Where was your child born?_____
29. What countries are most important to your family's cultural background?_____
-
30. Are you interested in sharing your cultural background or other interests with the children at SDC by reading stories,sharing games, songs, food,or arts and crafts projects?) If yes, what would you like to share and when is the best day and time for you?_____
-
31. Is there anything else you feel is important for us to know about the child, the child's family or culture?_____
-
32. Is there anybody else who regularly cares for your child? Who?_____
-
33. What is Mom's job/profession?_____
34. What are Mom's hobbies?_____
35. What is Dad's job/profession?_____
36. What are Dad's hobbies?_____
37. Is either parent interested in chaperoning field trips?_____
38. Is either parent interested in joining our Board of **Directors**?_____
39. Is there anything else we should know about your child?_____
-

Thank you for providing this information about your child. It is our intention to make your child feel comfortable while in our care.

Signature of the person completing this form:_____ Date_____



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Sharon Day Care Registration Form

Today's Date: _____ Date child will begin at SDC: _____

Child Information:

Child's Name _____ Date of Birth _____

Address: _____ Phone: _____

Primary Language: _____ Race: _____ Ethnic Background: _____

Child's Identifying Information:

Eye Color _____ Hair Color _____ Sex _____ Height _____ Weight _____

Identifying Marks: _____

Parent/Guardian Information:

Mother's Name: _____ Home Telephone: _____ Email: _____

Home Address: _____

Business Name: _____ Business Address: _____

Business Telephone: _____ Hours at Work: _____

Father's Name: _____ Home Telephone(if different): _____

Home Address(if different): _____

Business Name: _____ Business Address: _____

Business Telephone: _____ Hours at Work: _____

Guardian's Name: _____ Home Telephone: _____

Home Address: _____

Business Name: _____ Business Address: _____

Business Telephone: _____ Hours at Work: _____

Child lives with (include all the persons in the home and relationship): _____

If Parent/Guardian cannot be contacted, notify:

Name: _____ Relationship to the child: _____

Address: _____ Telephone: _____

Is this person authorized to pick up child? (Please circle one) Yes No

Child's Physician/Clinic: _____ Telephone: _____

Parent/Guardian Signature: _____ Date: _____

There is a yearly \$50.00 non-refundable registration fee, when you register your child for enrollment at SDC. This money will be applied to our Enrichment Fund and will be used throughout the year for field trips, Tom the Music Man, dancing, drumming as well as many in house special programs.



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Dear Parents,

When your child begins school at the Sharon Day Care Center he/she will need to bring:

1. A nutritious snack (fruit, vegetables, cheese, etc) and drink (if your child stays past 3:30, please send an additional snack and drink for PM snack).
2. A lunch and drink. We will no longer be purchasing hot lunch from SCS but instead will be introducing pizza Fridays. We will also be offering milk for twenty five cents per day.
3. A full change of clothing, **labeled** (including underwear and socks) to be kept at the center. A labeled shoe box or plastic shoe box to put the clothing into in the bottom of the cubby (No plastic bags please).
4. A crib size sheet, blanket and pillow if your child is staying for rest. Please provide a **sturdy, labeled, canvas** bag for storing the items.
5. Two recent photos of your child. One to be placed in his/her cubby and the other to be used for the bulletin board (one will be returned).
6. Children should wear sneakers or keep a pair in the cubby for outside play.

Please note: We will not be able to heat up lunches because it takes too much time away from the children. Please put warm lunches in an insulated thermos for your child. This will keep it warm until lunchtime.

Thank you.
The Day Care Staff

**Tuition Fees 2017-2018
(Updated 8/2016)**

Infant and Toddler:

Half Day	\$40
Full Day	\$55

Preschool:

Half Day	\$25
Full Day	\$40
¾ Day	\$32
Before School 7:30- 8:30	\$8
After School 3:00 – 5:30	\$15

There is annual, **non-refundable**, \$50 registration fee that is due at the time of registration.

Please plan to be punctual when picking up your child. Late charge for parents who pick up after 5:30 PM will be \$25 per 15 minutes (or any part thereof). Half day participants who pick up more than 15 minutes late will be assessed a fee of \$10; 30 minutes late will be charged the full day rate.



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Parent Acknowledgement and Receipt of Parent Handbook and the Behavior Management Policy

I have received, read, and understand the Parent Handbook, as well as discussing the behavior management in the classroom.

Parent/Guardian Signature

Date

Discipline

The goal of discipline at the Sharon Day Care is to encourage inner control and the growth of Self-discipline. The staff will praise and reinforce positive behavior. When a Child's behavior is inappropriate, the staff will help the child think of appropriate, alternative ways of expression. Self-discipline is achieved when a child can make appropriate decisions about their actions without continually relying on others to tell them what expected behavior in a given situation is.

Teachers will:

- *Maintain developmentally appropriate expectations of the children in their care.
- *Model positive behavior, soft voices, consideration and respect for others.
- *Allow children time to problem solve before interacting.
- *If intervention is needed, remove the child from the situation, speak to them in a clear, firm voice and follow through on consequences relevant to the behavior.
- *Encourage children to express their feelings. Avoid trying to have an angry child sit quietly, but instead speak to the child about their behavior.
- *Use time out as a last resort, and as a way to allow the child the needed space to be able to think about their actions. Redirection should be tried first. Encourage children to decide when they are ready to rejoin the group and have them talk about what actions led to the time out.
- *Discipline will never be neglectful, corporal, humiliating, or frightening. Discipline will not be connected with food, rest or toileting.



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TUITION POLICY

Please read the tuition policy carefully. After reading each numbered section, write your initials at the end of the section. This and your signature will indicate to us that you have read and understand the points laid out within this policy. If you have any questions, please ask the Executive Director. After you return this form, you will receive a copy signed by the Executive Director.

- 1. Tuition is paid in advance and may be paid weekly, monthly, or quarterly.**
- 2. Accounts will become delinquent on the Monday following a missed payment. A 20% late fee will be added to your account each week until the balance is paid in full. Any fees not paid by the following Friday will jeopardize your child's day care slot. Sharon Day Care will take legal action if necessary to collect unpaid tuition. In the event we take legal action, in addition to the amount owed, you agree to pay all costs of collection including a reasonable attorney's fee.**
- 3. Tuition and fees are non-refundable. Exceptions may be made in case of illness of ten (10) consecutive days or more.**
- 4. With two weeks advance written notice, there will be a 50% reduction in fees for family vacations (a **minimum of 5 consecutive days and a maximum of 2 weeks per year**). If such notice is not received, payment of tuition is due in full.**
- 5. No tuition will be charged for holidays on which the Center is closed or during the center's scheduled vacation breaks (the week before SCS begins), Thanksgiving and the Friday after, Dec 24, 25, 26, New Year's Day, Good Friday, Memorial Day, and July 4. When the Center is closed due to severe weather conditions or any other emergency, a tuition credit (to be applied at the end of the year) will be granted.**
- 6. Parents who withdraw a child from the Center without a week's notice will be required to pay that week's tuition.**
- 7. All prior tuition and fees must be paid in full, before enrollment for the coming year can be allowed.**
- 8. Please ensure pick up is punctual. If a child is in care after 5:30 p.m. a charge of \$25 will be charged for every 15 minutes (or any part there of). Half day participants picked up more than 15 minutes late will be assessed a fee of \$10; more than 30 minutes late will be charged the full day rate.**

**SHARON DAY CARE
TUITION AGREEMENT**

My child _____ will be enrolled at Sharon Day Care for ___ days at a weekly rate of _____. **I have read the provisions concerning tuition payment and agree to abide by them.** I realize that failure to meet my financial obligations to Sharon Day Care may result in the dismissal of my child by the Board of Directors.

Parent/Guardian Name: _____

Signature

Date

Executive Director: _____

Signature

Date



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Financial Assistance Application

Please complete the following and return the application to Carrie Olsen, Director as soon as possible. All information is kept confidential.

Date of application _____

Name of Parent/Guardian _____

Address _____

Telephone number _____

Name of Child _____

1. Total income for 20__ : _____
Please include a copy of your _____ income tax return. (If both parents are working and filed separately, please include a copy of both returns). Also, include pay stubs from the last 3 weeks of employment/unemployment.
2. Are you presently receiving welfare payments or other government support _____
If so, in what amount _____
3. Are you receiving child support and/or alimony _____
If so, in what amount _____
4. Number of people in the family _____
5. Number of people in the household _____
6. Number of children attending Sharon Day Care Center _____
7. Number of children in family _____
8. List weekly payments for other childcare expenses _____
9. Number of days and hours per week child will be attending Sharon Day Care Center _____

Permission For Emergency Medical Care

In case of an emergency, I give permission to the staff of the Sharon Day Care Center to secure emergency medical care and/or hospitalization for my child _____.

I understand that the center will make every effort to contact me in an emergency situation, however, care and treatment of my child is the highest priority.

My child's pediatrician is _____.

Parent's Signature

Date

Emergency Contacts

List two neighbors or nearby relatives who will assume temporary care of your child(ren) if you cannot be reached in the event of your child's emergency illness or the center's emergency closing.

Name _____ Telephone(s) _____

Name _____ Telephone(s) _____

Please notify the director of any change in the above names.

Yes, I want my name, mailing address, child's name, phone number and email address included in the SDC Directory. This list will be available to all other parents at Sharon Day Care Center.

Child's Name: _____

Parent Name: _____

Parent Signature: _____ Date: _____

Allergy Posting Permission Slip:

If your child has an allergy, please sign below giving Sharon Day Care Center permission to post your child's name and allergy in classrooms near meal preparation areas and program areas.

Child's Name: _____ Allergy: _____

Parent Name: _____

Parent Signature: _____ Date: _____

Permission form to leave the Daycare Center Property

Yes, I give permission for _____ to leave the enclosed play yard and go onto the basketball court, the soccer field, to ride trikes/bikes on the paved area and to take nature walks and stroller rides with their teachers.

This is a blanket permission slip for August _____ - August _____ for any day when my child is in attendance.

Child's Name: _____

Parent Name: _____

Parent Signature: _____ Date: _____

PHOTO RELEASE FORM

Photographs of the children at Sharon Day Care are used in many areas/venues. We love to display photographs of the daily activities on the walls, for special projects and occasionally place photos in local papers for our family, friends and community to see. Please indicate below when you would be willing for us to take or display a photo of your child.

- For classroom photo album, bulletin boards, school-made books, etc
- During birthday parties, special events at the center, etc.
- For publications, advertising, website, and/or public relations
- For educational workshops and presentations
- For parent/teacher conferences, special parent projects

I/We hereby give consent to Sharon Day Care to use my child's photograph (motion or still) for above designated purposes.

Child's Name _____

Parent/Guardian Name _____

Parent/Guardian Signature _____

Date _____

SUNSCREEN AND BUG REPELLANT PERMISSION 2016

Please apply sunscreen before drop-off daily. Additional sunscreen and/or bug repellent will be applied by your child's teacher in the afternoon, if necessary. Please label the sunscreen and bug repellent with your child's name. Thank you ☺

Child Name _____

I give the Sharon Day Care Center staff permission to apply the sunscreen and bug repellent I provide to my child named above. I have labeled the sunscreen and bug repellent with my child's name.

Parent/Guardian Signature _____

Date ___/___/___

**Sharon Day Care Center
Calendar of Closings 2017-2018**

August 21-25	Shut-down
September 4	Labor Day
November 23-24	Thanksgiving Break
December 25-26	Christmas Break
January 1	News Year's Break
March 30	Good Friday
May 28	Memorial Day
June	Days following Region 1's last day of school.
July 4	Fourth of July
August	The week before Region 1 opens

****Please note that this calendar is subject to change, as much advance notice as possible will be given in such cases. Other events will be planned and information posted throughout the year such as Open House, Fundraisers, Family Events, etc.**

Please be aware of our inclement weather policy, we follow the Region 1 school district for closing and delays and early dismissals.. If Region 1 is closed, the center will also be closed. If Region 1 has a 90 minute delay we will also have a 90 minute delay. If Region 1 has a 1:00 dismissal we will also close at 1:00. Notifications will be on WFSB and wfsb.com, FB and via email.



State of Connecticut Department of Education

Early Childhood Health Assessment Record

(For children ages birth – 5)



To Parent or Guardian: In order to provide the best experience, early childhood providers must understand your child's health needs. This form requests information from you (Part I) which will be helpful to the health care provider when he or she completes the health evaluation (Part II). State law requires complete primary immunizations and a health assessment by a physician, an advanced practice registered nurse, a physician assistant, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to entering an early childhood program in Connecticut.

Please print

Child's Name (Last, First, Middle)	Birth Date (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
Early Childhood Program (Name and Phone Number)	Race/Ethnicity	
Primary Health Care Provider:	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> Other	
Name of Dentist:		
Health Insurance Company/Number* or Medicaid/Number*		
Does your child have health insurance? Y N		
Does your child have dental insurance? Y N		
Does your child have HUSKY insurance? Y N		

If your child does not have health insurance, call 1-877-CT-HUSKY

* If applicable

Part I — To be completed by parent/guardian.

Please answer these health history questions about your child before the physical examination.

Please circle Y if "yes" or N if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Frequent ear infections	Y	N	Asthma treatment	Y	N
Allergies to food, bee stings, insects	Y	N	Any speech issues	Y	N	Seizure	Y	N
Allergies to medication	Y	N	Any problems with teeth	Y	N	Diabetes	Y	N
Any other allergies	Y	N	Has your child had a dental examination in the last 6 months	Y	N	Any heart problems	Y	N
Any daily/ongoing medications	Y	N				Emergency room visits	Y	N
Any problems with vision	Y	N	Very high or low activity level	Y	N	Any major illness or injury	Y	N
Uses contacts or glasses	Y	N	Weight concerns	Y	N	Any operations/surgeries	Y	N
Any hearing concerns	Y	N	Problems breathing or coughing	Y	N	Lead concerns/poisoning	Y	N
Developmental — Any concern about your child's:						Sleeping concerns	Y	N
1. Physical development	Y	N	5. Ability to communicate needs	Y	N	High blood pressure	Y	N
2. Movement from one place to another	Y	N	6. Interaction with others	Y	N	Eating concerns	Y	N
			7. Behavior	Y	N	Toileting concerns	Y	N
3. Social development	Y	N	8. Ability to understand	Y	N	Birth to 3 services	Y	N
4. Emotional development	Y	N	9. Ability to use their hands	Y	N	Preschool Special Education	Y	N

Explain all "yes" answers or provide any additional information:

Have you talked with your child's primary health care provider about any of the above concerns? Y N

Please list any medications your child will need to take during program hours:

All medications taken in child care programs require a separate Medication Authorization Form signed by an authorized prescriber and parent/guardian.

I give my consent for my child's health care provider and early childhood provider or health/nurse consultant/coordinator to discuss the information on this form for confidential use in meeting my child's health and educational needs in the early childhood program.	Signature of Parent/Guardian _____ Date _____
---	--

Part II – Medical Evaluation

Health Care Provider must complete and sign the medical evaluation, physical examination and immunization record.

Child's Name _____ Birth Date _____ Date of Exam _____
(mm/dd/yyyy) (mm/dd/yyyy)

I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider.

*HT _____ in/cm _____ % *Weight _____ lbs. _____ oz / _____ % BMI _____ / _____ % *HC _____ in/cm _____ % *Blood Pressure _____ / _____
(Birth – 24 months) (Annually at 3 – 5 years)

Screenings

<p>*Vision Screening</p> <p><input type="checkbox"/> EPSDT Subjective Screen Completed (Birth to 3 yrs)</p> <p><input type="checkbox"/> EPSDT Annually at 3 yrs (Early and Periodic Screening, Diagnosis and Treatment)</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">Type:</td> <td style="width: 15%;">Right</td> <td style="width: 15%;">Left</td> </tr> <tr> <td>With glasses</td> <td style="text-align: center;">20/</td> <td style="text-align: center;">20/</td> </tr> <tr> <td>Without glasses</td> <td style="text-align: center;">20/</td> <td style="text-align: center;">20/</td> </tr> </table> <p><input type="checkbox"/> Unable to assess</p> <p><input type="checkbox"/> Referral made to: _____</p>	Type:	Right	Left	With glasses	20/	20/	Without glasses	20/	20/	<p>*Hearing Screening</p> <p><input type="checkbox"/> EPSDT Subjective Screen Completed (Birth to 4 yrs)</p> <p><input type="checkbox"/> EPSDT Annually at 4 yrs (Early and Periodic Screening, Diagnosis and Treatment)</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">Type:</td> <td style="width: 15%;">Right</td> <td style="width: 15%;">Left</td> </tr> <tr> <td></td> <td style="text-align: center;"><input type="checkbox"/> Pass</td> <td style="text-align: center;"><input type="checkbox"/> Pass</td> </tr> <tr> <td></td> <td style="text-align: center;"><input type="checkbox"/> Fail</td> <td style="text-align: center;"><input type="checkbox"/> Fail</td> </tr> </table> <p><input type="checkbox"/> Unable to assess</p> <p><input type="checkbox"/> Referral made to: _____</p>	Type:	Right	Left		<input type="checkbox"/> Pass	<input type="checkbox"/> Pass		<input type="checkbox"/> Fail	<input type="checkbox"/> Fail	<p>*Anemia: at 9 to 12 months and 2 years</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">*Hgb/Hct:</td> <td style="width: 50%;">*Date:</td> </tr> </table> <p>*Lead: at 1 and 2 years; if no result screen between 25 – 72 months</p> <p>Lead poisoning (≥ 10ug/dL)</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	*Hgb/Hct:	*Date:
Type:	Right	Left																				
With glasses	20/	20/																				
Without glasses	20/	20/																				
Type:	Right	Left																				
	<input type="checkbox"/> Pass	<input type="checkbox"/> Pass																				
	<input type="checkbox"/> Fail	<input type="checkbox"/> Fail																				
*Hgb/Hct:	*Date:																					
<p>*TB: High-risk group? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Test done: <input type="checkbox"/> No <input type="checkbox"/> Yes Date: _____</p> <p>Results: _____</p> <p>Treatment: _____</p>	<p>*Dental Concerns <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><input type="checkbox"/> Referral made to: _____</p> <p>Has this child received dental care in the last 6 months? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>*Result/Level: _____ *Date: _____</p> <p>Other: _____</p>																				

***Developmental Assessment: (Birth – 5 years)** No Yes **Type:** _____

Results: _____

***IMMUNIZATIONS** Up to Date or Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

Asthma No Yes: Intermittent Mild Persistent Moderate Persistent Severe Persistent Exercise induced
If yes, please provide a copy of an Asthma Action Plan

Rescue medication required in child care setting: No Yes

Allergies No Yes: _____
 Epi Pen required: No Yes
 History/risk of Anaphylaxis: No Yes: Food Insects Latex Medication Unknown source
If yes, please provide a copy of the Emergency Allergy Plan

Diabetes No Yes: Type I Type II **Other Chronic Disease:** _____

Seizures No Yes: Type: _____

This child has the following problems which may adversely affect his or her educational experience:
 Vision Auditory Speech/Language Physical Emotional/Social Behavior

This child has a developmental delay/disability that may require intervention at the program.

This child has a special health care need which may require intervention at the program, e.g., special diet, long-term/ongoing/daily/emergency medication, history of contagious disease. *Specify:* _____

No Yes This child has a medical or emotional illness/disorder that now poses a risk to other children or affects his/her ability to participate safely in the program.

No Yes Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.

No Yes This child may fully participate in the program.

No Yes This child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.) _____

No Yes Is this the child's medical home? I would like to discuss information in this report with the early childhood provider and/or nurse/health consultant/coordinator.

Signature of health care provider MD / DO / APRN / PA	Date Signed	Printed/Stamped Provider Name and Phone Number
---	-------------	--

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) _____

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP/DT						
IPV/OPV						
MMR						
Measles						
Mumps						
Rubella						
Hib						
Hepatitis A						
Hepatitis B						
Varicella						
PCV* vaccine					*Pneumococcal conjugate vaccine	
Rotavirus						
MCV**					**Meningococcal conjugate vaccine	
Flu						
Other						

Disease history for varicella (chickenpox) _____

(Date)

(Confirmed by)

Exemption: Religious _____ Medical: Permanent _____ †Temporary _____ Date _____
 †Recertify Date _____ †Recertify Date _____ †Recertify Date _____

Immunization Requirements for Connecticut Day Care, Family Day Care and Group Day Care Homes

Vaccines	Under 2 months of age	By 3 months of age	By 5 months of age	By 7 months of age	By 16 months of age	16-18 months of age	By 19 months of age	2-3 years of age (24-35 mos.)	3-5 years of age (36-59 mos.)
DTP/DTaP/DT	None	1 dose	2 doses	3 doses	3 doses	3 doses	4 doses	4 doses	4 doses
Polio	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
MMR	None	None	None	None	1 dose after 1st birthday ¹	1 dose after 1st birthday ¹	1 dose after 1st birthday ¹	1 dose after 1st birthday ¹	1 dose after 1st birthday ¹
Hep B	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
HIB	None	1 dose	2 doses	2 or 3 doses depending on vaccine given ³	1 booster dose after 1st birthday ⁴	1 booster dose after 1st birthday ⁴	1 booster dose after 1st birthday ⁴	1 booster dose after 1st birthday ⁴	1 booster dose after 1st birthday ⁴
Varicella	None	None	None	None	None	None	1 dose after 1st birthday or prior history of disease ^{1,2}	1 dose after 1st birthday or prior history of disease ^{1,2}	1 dose after 1st birthday or prior history of disease ^{1,2}
Pneumococcal Conjugate Vaccine (PCV)	None	1 dose	2 doses	3 doses	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday
Hepatitis A	None	None	None	None	1 dose after 1st birthday ⁵	1 dose after 1st birthday ⁵	1 dose after 1st birthday ⁵	2 doses given 6 months apart ⁵	2 doses given 6 months apart ⁵
Influenza	None	None	1 or 2 doses	1 or 2 doses	1 or 2 doses ⁶	1 or 2 doses ⁶	1 or 2 doses ⁶	1 or 2 doses ⁶	1 or 2 doses ⁶

1. Laboratory confirmed immunity also acceptable
2. Physician diagnosis of disease
3. A complete primary series is 2 doses of PRP-OMP (PedvaxHIB) or 3 doses of HbOC (ActHib or Pentacel)
4. As a final booster dose if the child completed the primary series before age 12 months. Children who receive the first dose of Hib on or after 12 months of age and before 15 months of age are required to have 2 doses. Children who received the first dose of Hib vaccine on or after 15 months of age are required to have only one dose
5. Hepatitis A is required for all children born after January 1, 2009
6. Two doses in the same flu season are required for children who have not previously received an influenza vaccination, with a single dose required during subsequent seasons

Initial/Signature of health care provider MD / DO / APRN / PA _____ Date Signed _____ Printed/Stamped Provider Name and Phone Number _____



Emergency Information Card

Doctor _____
Address _____

Phone _____

Child's Name _____ Nickname _____

Birthdate _____ Address _____ Home-Phone _____ Cell-Phone _____

Mother's Name _____ Address (if different) _____

Father's Name _____ Address (if different) _____

Mother's Employer _____ Phone _____ Work Hours _____

Father's Employer _____ Phone _____ Work Hours _____

IN EMERGENCY Call _____ Phone _____ Relationship _____

Child's Arrival _____ a.m. Departure _____ p.m.

Authorized to pick up child _____

ALLERGIES _____

SPECIAL NOTES (Write in RED) Physical Problems _____