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________

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

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 Hand Book 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. <u>A 20% late fee will be added to your account each week until the balance is paid in full.</u> 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

2008/09

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

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 repellant will be applied by your child's teacher in the afternoon, if necessary. Please label the sunscreen and bug repellant with your child's name. Thank you ☺

Child Name_______________________________

I give the Sharon Day Care Center staff permission to apply the sunscreen and bug repellant I provide to my child named above. I have labeled the sunscreen and bug repellant 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)	☐ Male ☐ 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 ☐ American Indian/Alaskan Native ☐ Hispanic/Latino ☐ Black, not of Hispanic origin ☐ Asian/Pacific Islander ☐ White, not of Hispanic origin ☐ Other	
Primary Health Care Provider: 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 ____________ (mm/dd/yyyy) Date of Exam ____________ (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 ____% (Birth – 24 months) ***Blood Pressure** ____ / ____ (Annually at 3 – 5 years)

Screenings

***Vision Screening**

☐ EPSDT Subjective Screen Completed (Birth to 3 yrs)

☐ EPSDT Annually at 3 yrs (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

☐ Unable to assess

☐ Referral made to: ____________

***Hearing Screening**

☐ EPSDT Subjective Screen Completed (Birth to 4 yrs)

☐ EPSDT Annually at 4 yrs (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
	☐ Pass	☐ Pass
	☐ Fail	☐ Fail

☐ Unable to assess

☐ Referral made to: ____________

***Anemia:** at 9 to 12 months and 2 years

***Hgb/Hct:** ***Date**

***Lead:** at 1 and 2 years; if no result screen between 25 – 72 months

Lead poisoning (≥ 10ug/dL)

☐ No ☐ Yes

***Result/Level:** ***Date**

Other:

***TB:** High-risk group? ☐ No ☐ Yes

Test done: ☐ No ☐ Yes Date: ______

Results: ____________

Treatment: ____________

***Dental Concerns** ☐ No ☐ Yes

☐ Referral made to: ____________

Has this child received dental care in the last 6 months? ☐ No ☐ Yes

***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

Child's Name: ______________________ Birth Date: ______________ REV. 8/2011

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 ______________________