Pennsylvania Ave Montessori – Enrollment Checklist

State Requirements:

- Enrollment application
- Child's Pre-Admission health history form (to be completed by parent)
- Immunization records (copy of all immunizations)
- Consent for medical treatment
- Child's Pre-Admission Physicians report (within 30 days of start date)
- Parent's rights
- Personal rights
- Receipt of school policies and procedures
- ID Emergency form

School requirements

- Tuition Agreement
- Photo Release form
- Admissions Agreement

Child's Name : _____ Starting Date : _____

Pennsylvania Ave Montessori

- PREPARATION FOR THE FIRST DAY

- Enrollment Packet
- Immunization Records (copy of all immunizations)
- Tuition Payment
- A complete change of clothes including dress, shirt, pants or shorts, socks and underwear. Please label each piece of clothing with your child's name in permanent marker.
- For children who are not completely toilet trained, please provide an adequate supply of wipes, pull-ups and extra clothing. When replenishing these items, please place them in your child's bin as needed.
- For naptime, children will need a blanket and a crib sheet. These items will be sent home at the end of each week to be laundered and returned by Monday. Please feel free to bring any items that will make falling asleep easier for your child, such as a stuffed toy or special blanket.
- Emergency packet: a Ziploc bag with shoes, pants, shirt, socks, and underwear, a soft toy and a picture of the family.
- Labeled Water Cup

If you have an infant, please see attached supply list -

- Signed Infants Need and Services Form
- A wallet size picture of your child

Pennsylvania Ave Montessori

Admission Agreement

I/We the undersigned parents/legal guardian(s) of_____do hereby agree to abide by the following terms and conditions:

My child will attend:

☐ 5days ☐ 4 days ☐ 3 days ☐ 2 days

Pay tuition at a rate of $ _____ (You will be notified at least 30 days in advance of a rate change).

- Monthly tuition is due on the first of each month. If tuition is not paid by the tenth of the month, you will be charged $25.00 each day your tuition remains unpaid.
- Weekly tuition is due on Monday. If tuition is not paid by Wednesday, you will be charged $20.00 each day your tuition remains unpaid.
- Pay a $15 charge on all returned checks due to insufficient funds.
- Pay a non-refundable registration fee of $125.00 is due upon registration.
- Give a 14 day notice in writing regarding the termination of enrollment of my/our child. Failure to give such notice will result in a charge of full month tuition.
- Agree to escort my child to and from the school or notify the school in writing of another adult authorized by me/us to do this. The child will be delivered to the Director or other designated person from the facility.
- Agree to sign in with my full name when the child is brought into the facility and to sign out when the child is taken out from the facility, on the sign in/out sheet provided. Failure to do so will be in violation of Section 1596.81 of the Health and Safety Code.
- Agree to be responsible for the payment of tuition on time. Failure to do so will subject my child to removal from the school.
- Agree that any absences do not result in a reduction of tuition, other than the vacation time specified in the operating policies and procedures handbook.
- Agree to send lunch with my child. Tuition covers snacks Monday — Friday and milk/juice at lunch.
- Children 6 weeks to 36 months old must complete an needs and service plan and update every three months.
- Agree to notify the Director or classroom teacher if I wish to celebrate my child's birthday during afternoon snack time.
- Pursuant to Title 22 of the California Administrative Code, I am aware that the Department of Social Services or agencies authorized by State or Federal Laws, whichever apply have the right to interview the child, school staff, and to inspect and audit all records maintained by the school without securing prior consent. The department has the right to observe the physical conditions of the child including the conditions indicating abuse and neglect and to have licensed medical professional examine the child.
- A child may be terminated from the school if it is deemed to be in the best interest of the child or if the school policies and procedures are violated.
- Refund Policy:

  The school is unable to allow make up or substitute days for times that a child is absent. There is no refund for days not attended. A refund of prepaid tuition will be made, provided two weeks written notice of intent to withdraw is given.

I/We acknowledge receiving copies of the Admission Agreement and the Parent Handbook containing the policies and procedures of this school. I/We further acknowledge having read, understood and fully agree to be bound by the terms of the Admission Agreement and by the rules and regulations found in the Parent Handbook.

_____ _____ _____ _____

Authorized School Representative Date

_____ _____ Facility Licensing #_____

Parent(s) or legal Guardian(s) Date

Pennsylvania Ave Montessori - **Tuition Agreement**

1. Monthly tuition is due by the 1st of every month. Weekly tuition is due on the first day that you attend. If tuition is not paid by the fifth of the month, a late fee of $100.00 will be automatically invoiced to your account on the 6th.

2. A 10% sibling discount is given if more than one child from the same family are enrolled.

3. All payments should be written to Pennsylvania Ave Montessori.

4. There will be no reduction in fees or refunds given for absences for any reason. (sickness, vacations, holidays etc.)

5. Part-time children may not switch days to replace a sick day, a day that we may be closed, or any missed days.

6. A one month/30 day written notice is required prior to withdrawing your child from the program. Parents are responsible for payments of services to the date of cancellation.

7. An unpaid balance may result in termination of service.

8. A late pickup fee is charged if a child is picked up later than the scheduled time. We charge $1 per minute per child. Please pay cash directly to the teacher in charge. Half day is after 12:15p.m. Full day is after 6:30p.m.

9. A bank fee of $25.00 will be charged for any returned checks.

10. If your account goes to collections, a service charge of 1 ½% per month will be added to overdue accounts. You will be liable for all legal and collections fees.

11. Late Parents/Emergency Contact Policy: The school administration will start calling all the phone numbers on file at 6:15 P.M. if no parents/emergency contact is reached before 7 P.M social services will be called in to assist in the protection of your child.

Parents signature:_____ Date:_____

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

PHYSICIAN'S REPORT—CHILD CARE CENTERS
(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

_____, born _____ is being studied for readiness to enter
(NAME OF CHILD) (BIRTH DATE)

_____. This Child Care Center/School provides a program which extends from 6 : 30
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to 6:30 a.m./p.m., 5 days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

_____ _____
(SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE) (TODAY'S DATE)

PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware:

Hearing: Allergies: medicine:

Vision: Insect stings:

Developmental: Food:

Language/Speech: Asthma:

Dental:

Other (Include behavioral concerns):

Comments/Explanations:

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
HIB MENINGITIS (REQUIRED FOR CHILD CARE ONLY) (HAEMOPHILUS B)	/ /	/ /	/ /	/ /	
HEPATITIS B	/ /	/ /	/ /		
VARICELLA (CHICKENPOX)	/ /	/ /			

SCREENING OF TB RISK FACTORS (listing on reverse side)

☐ Risk factors not present; TB skin test not required.

☐ Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).
___ Communicable TB disease not present.

I have ☐ have not ☐ reviewed the above information with the parent/guardian.

Physician: _____ Date of Physical Exam: _____
Address: _____ Date This Form Completed: _____
Telephone: _____ Signature _____

☑ Physician ☑ Physician's Assistant ☑ Nurse Practitioner

PHOTOGRAPHY & VIDEO PERMISSION

Pennsylvania Avenue Montessori takes care that any use, display, or dissemination of photographs or videos of children is accomplished in a thoughtful and safe manner. We regularly take photographs and videos of children enrolled. They may be shared with you and /or other families. Photos may also be used to better communicate with families, to illustrate the daily curriculum, to chronicle a child's development, or to document center activities. Additionally, they may be used for other centers, general business, and marketing purposes; including online.

____I give permission for Pennsylvania Avenue Montessori to take photographs and videos of my child and use these materials as described above.

____**I DO NOT** give permission for Montessori of Valencia to take photos and videos of my child or use these materials in any way as described above.

Parent Signature_____ Date _____

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S/FATHER'S DOMESTIC PARTNER'S NAME		DOES FATHER/FATHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
MOTHER'S/MOTHER'S DOMESTIC PARTNER'S NAME		DOES MOTHER/MOTHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?		DATE OF LAST PHYSICAL/MEDICAL EXAMINATION

DEVELOPMENTAL HISTORY (*For infants and preschool-age children only)

WALKED AT*	BEGAN TALKING AT*	TOILET TRAINING STARTED AT*
MONTHS	MONTHS	MONTHS

PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

	DATES		DATES		DATES
☐ Chicken Pox		☐ Diabetes		☐ Poliomyelitis	
☐ Asthma		☐ Epilepsy		☐ Ten-Day Measles (Rubeola)	
☐ Rheumatic Fever		☐ Whooping cough		☐ Three-Day Measles (Rubella)	
☐ Hay Fever		☐ Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? ☐ YES ☐ NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF

DAILY ROUTINES (*For infants and preschool-age children only)

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*

DIET PATTERN:
(What does child usually eat for these meals?)

BREAKFAST

LUNCH

DINNER

WHAT ARE USUAL EATING HOURS?
BREAKFAST _____
LUNCH _____
DINNER

ANY FOOD DISLIKES?	ANY EATING PROBLEMS?

IS CHILD TOILET TRAINED?* ☐ YES ☐ NO	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?* ☐ YES ☐ NO	WHAT IS USUAL TIME?*
WORD USED FOR "BOWEL MOVEMENT"*		WORD USED FOR URINATION*	

PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE? ☐ YES ☐ NO	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)? ☐ YES ☐ NO	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
DOES CHILD USE ANY SPECIAL DEVICE(S): ☐ YES ☐ NO	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? ☐ YES ☐ NO	IF YES, WHAT KIND:

PARENT'S EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENTS, BROTHERS, SISTERS AND OTHER CHILDREN?

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT'S SIGNATURE	DATE

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

IDENTIFICATION AND EMERGENCY INFORMATION
CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Authorized Representative

CHILD'S NAME LAST	MIDDLE	FIRST	SEX	TELEPHONE ( )
ADDRESS NUMBER STREET	CITY	STATE ZIP		BIRTHDATE
FATHER'S/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME LAST	MIDDLE	FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS NUMBER STREET	CITY	STATE ZIP		HOME TELEPHONE ( )
MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME LAST	MIDDLE	FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS NUMBER STREET	CITY	STATE ZIP		HOME TELEPHONE ( )
PERSON RESPONSIBLE FOR CHILD LAST NAME	MIDDLE	FIRST	HOME TELEPHONE ( )	BUSINESS TELEPHONE ( )

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

☐ CALL EMERGENCY HOSPITAL ☐ OTHER EXPLAIN: _____

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE | DATE

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION | DATE LEFT

IMPORTANT INFORMATION FOR PARENTS

CAREGIVER BACKGROUND CHECK PROCESS
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

The California Department of Social Services works to protect the safety of children in child care by licensing child care centers and family child care homes. Our highest priority is to be sure that children are in safe and healthy child care settings. California law requires a background check for any adult who owns, lives in, or works in a licensed child care home or center. Each of these adults must submit fingerprints so that a background check can be done to see if they have any history of crime. If we find that a person has been convicted of a crime other than a minor traffic violation or a marijuana-related offense covered by the marijuana reform legislation codified at Health and Safety Code sections 11361.5 and 11361.7, he/she cannot work or live in the licensed child care home or center unless approved by the Department. This approval is called an exemption.

A person convicted of a crime such as murder, rape, torture, kidnapping, crimes of sexual violence or molestation against children **cannot by law be given an exemption that would allow them to own, live in or work in** a licensed child care home or center. If the crime was a felony or a serious misdemeanor, the person must leave the facility while the request is being reviewed. If the crime is less serious, he/she may be allowed to remain in the licensed child care home or center while the exemption request is being reviewed.

How the Exemption Request is Reviewed

We request information from police departments, the FBI and the courts about the person's record. We consider the type of crime, how many crimes there were, how long ago the crime happened and whether the person has been honest in what they told us.

The person who needs the exemption must provide information about:

- The crime
- What they have done to change their life and obey the law
- Whether they are working, going to school, or receiving training
- Whether they have successfully completed a counseling or rehabilitation program

The person also gives us reference letters from people who aren't related to them who know about their history and their life now.

We look at all these things very carefully in making our decision on exemptions. By law this information cannot be shared with the public.

How to Obtain More Information

As a parent or authorized representative of a child in licensed child care, you have the right to ask the licensed child care home or center whether anyone working or living there has an exemption. If you request this information, and there is a person with an exemption, the child care home or center must tell you the person's name and how he or she is involved with the home or center and give you the name, address, and telephone number of the local licensing office. You may also get the person's name by contacting the local licensing office. You may find the address and phone number on our website. The website address is **http://ccld.ca.gov/contact.htm**

NEBULIZER CARE CONSENT/VERIFICATION
CHILD CARE FACILITIES

This form may be used to show compliance with Health and Safety Code Section 1596.798 before a child care licensee or staff person administers inhaled medication to a child in care. A copy of the completed form should be filed in the child's record and in the personnel file. ***A separate form must be filled out for each person who administers inhaled medication to the child.***

I,_____, give my consent for_____,
(PRINT NAME OF AUTHORIZED REPRESENTATIVE) (PRINT NAME OF LICENSEE OR STAFF PERSON)

who work(s) at _____,
(PRINT NAME AND ADDRESS OF CHILD CARE FACILITY)

to administer inhaled medication to my child,_____, and to contact my child's health care provider.
(PRINT NAME OF CHILD)

In addition, I certify that I have personally instructed the above-named licensee or staff person on how to administer inhaled medication to my child.

I have also provided the child care facility with written instructions from my child's physician, or from a health care provider working under the supervision of my child's physician (for example, a physician's assistant, nurse practitioner or registered nurse). These instructions include:

- Specific indications (such as symptoms) for administering the inhaled medication in accordance with the physician's prescription.
- Potential side effects and expected response.
- Dose form and amount to be administered in accordance with the physician's prescription.
- Actions to be taken in the event of side effects or incomplete treatment response in accordance with the physician's prescription. This includes actions to be taken in an emergency.
- Instructions for proper storage of the medication.
- The telephone number and address of the child's physician.

SIGNATURE OF AUTHORIZED REPRESENTATIVE	DATE

ADDRESS OF AUTHORIZED REPRESENTATIVE

HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER

CONSENT FOR EMERGENCY MEDICAL TREATMENT-
Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

_____ TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____ . THIS CARE MAY BE GIVEN UNDER
NAME

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

DATE

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE
( )

WORK PHONE
( )

PERSONAL RIGHTS

Child Care Centers

Personal Rights, See Section 101223 for waiver conditions applicable to Child Care Centers.

(a) Child Care Centers. Each child receiving services from a Child Care Center shall have rights which include, but are not limited to, the following:

(1) To be accorded dignity in his/her personal relationships with staff and other persons.

(2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.

(3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with daily living functions, including eating, sleeping, or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.

(4) To be informed, and to have his/her authorized representative, if any, informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency and of information regarding confidentiality.

(5) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis. In Child Care Centers, decisions concerning attendance at religious services or visits from spiritual advisors shall be made by the parent(s), or guardian(s) of the child.

(6) Not to be locked in any room, building, or facility premises by day or night.

(7) Not to be placed in any restraining device, except a supportive restraint approved in advance by the licensing agency.

THE REPRESENTATIVE/PARENT/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

NAME

CCLD

ADDRESS

1605 E Palmdale Blvd Suite A

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
Palmdale	CA 93550	661-789-6944

DETACH HERE

TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE:

PLACE IN CHILD'S FILE

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

ACKNOWLEDGMENT: I/We have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22, at the time of admission to:

(PRINT THE NAME OF THE FACILITY)	(PRINT THE ADDRESS OF THE FACILITY)

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)	(DATE)

Pennsylvania Ave Montessori – **Infant and Toddler Care Plan**

This form is required to be completed/ updated four times per year or as your child's needs change. Changes must be reviewed with your child's teacher. Revision dates must be initialed by the teacher and you must sign the form with the date of revision.

Date of Initial Completion : ___/___/___ Arrival Time : _____ Pick- up Time: _____

Child's Name : _____ D.O.B : _____

Parent/Guardian's Name : _____

Revision Dates : ___/___/___ (____Initials) ___/___/___ (____Initials) ___/___/___ (____Initials)

FEEDING PLAN

Child is to be fed the following: o Breast Milk o Formula – Brand _____ o Milk – Whole _____ o Milk – Other _____ o Juice: _____	Child now uses: o Bottle o Cup o Spoon o Fork	What age do you plan to introduce your child to: o Bottle _____ o Cup _____ o Spoon _____ o Fork _____
Child is to currently eating solids? o Yes o No	Child can feed himself? o Yes o No	What age will you begin to introduce solid foods? (if applicable) _____
How many ounces or cups per day? o Breast Milk _____ o Formula – Brand _____ o Milk _____ o Juice: _____	Approximate what time do you offer solids food at home? _____ _____	What time do you want us to offer solids foods? _____ _____ _____
Foods your child likes: _____ _____ _____	Foods your child dislikes: _____ _____ _____	Is your physician's medical statement regarding any dietary needs on file? o Yes o No
Food allergy Instructions: _____		
Special dietary instruction from your child's pediatrician relating to diet: _____		

SLEEPING PATTERNS

Does your child nap in the morning?	Does your child nap in the afternoon?	Does your child use a transitional object?
o Yes o No o What time? _____ o How long? _____	o Yes o No o What time? _____ o How long? _____	o Blanket _____ o Pacifier _____ o Other _____

Special sleep instructions:

_____

NOTE: As recommended by the American Academy of Pediatrics, Infants must be placed on their backs to sleep and with no items in the crib, including blankets. A child may move to their preferred position. Any request for an alternate sleeping position must be accompanied by documentation form your child's physician. Sleep sacks are recommended in place of a blanket.

DIAPERING

Diapering	When did your child begin toilet learning? _____ How does your child alert you that he wants to use the toilet? _____	What items are utilized in toilet learning at home?
o Cloth Diapers _____ o Disposable Diapers _____ o Wipes _____		o Training pants _____ o Potty Chair _____ o Toilet _____ o Other _____

Other products or special instructions:

_____

NOTE: 01. The use of powder is not authorized in our schools
02. The company must have a current completed Non Prescription Medical Treatment Instructions, Consent and waiver form on file for the use of all topical ointments (diaper cream, sunscreen, etc)

CARE NOTES

Please share any additional information or services needed that will aid in the care of your child:

_____

All parties below have reviewed and discussed the information contained on this Infant/ Toddler Care plan

Parent / Guardian Signature : _____ Initial Completion Date : _____

Parent / Guardian Signature : _____ First Revision Date : _____

Parent / Guardian Signature : _____ Second Revision Date : _____

Parent / Guardian Signature : _____ Third Revision Date : _____

Teacher Signature : _____ Date : _____

Director Signature : _____ Date : _____

Safe Sleep Policy for Infants

Safe sleep and napping practices reduce the risk of Sudden Infant Death Syndrome (SIDS) and the spread of contagious diseases. SIDS is the unexpected death of a seemingly healthy infant under one year of age for whom no cause of death can be determined.

In order to maintain safe sleep practices, these policies and procedures will be followed:

Infant Sleep Practices and Environment:

1. Healthy infants will always be put to sleep on their backs. Side sleeping is not as safe as back sleeping

2. If a parent/guardian requests that their child be put to sleep in a position other than on their back, or requires a wedge. Parents provide a Physician's signed note that explains how the infant should be put to sleep and the medical reason for this position. This note will be kept in the child's medical file and all staff will be notified of the infant's prescribed sleep position.

3. Infants will be placed to sleep on a firm mattress that fits tightly in a crib that meets Consumer Product Safety Commission safety standards. The sheet will fit the mattress snugly.

4. No toys, stuffed animals, pillows, bumpers, blankets or sleep devices (unless ordered by a health care provider). No teething necklaces or pacifiers with strings.

5. If the infant requires additional warmth, a Sleep Sack can be used.

6. Overheating is one of the risk factors for SIDS; to avoid overheating:

   a. Keep the room at a temperature that is comfortable for a lightly clothed adult, avoid blankets and bedding.

7. The infant's head will remain uncovered when she sleeps.

8. When an infant can easily turn over from back to front and front to back, the infant will be put to sleep on his back but will be allowed to assume his preferred sleep position.

9. Sleeping infants will be visually supervised at all times.

10. Awake infants will have supervised "Tummy Time" to allow for the development of strong back and neck muscles and prevent the development of flat areas on the head.

11. The time infants spend in a car seat, swing will be limited as this can delay motor development and may also cause the infant to develop a flat area on the back of her head. If the child falls asleep in these devices, they must be moved to their crib.

12. Pacifier use has been shown to decrease the risk for SIDS. Infants may be offered a pacifier when they are in the crib if parents offer a pacifier at home. Pacifiers will not be attached by a string or to the infant's clothing. Pacifiers will not be reinserted if they fall out after the infant is asleep.

Signature:_____ Date : _____