COMMUNITY
CENTER of HOPE

ENROLLMENT AND TUITION AGREEMENT

First/Middle/Last Name: _____ DOB: _____

Address: _____ City: _____ Zip Code: _____

Person(s) Responsible for Tuition: _____

Please specify your child's attendance schedule below. If you have a varying schedule, please provide your schedule for the upcoming week prior to the week beginning so that we may plan according to anticipated attendance. PLEASE READ THE HANDBOOK ABOUT DAILY SCHEDULES AND RATES!

Day of the Week	Drop-Off Time	Pick-Up Time
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

The program administrator/director will fill out the tuition portion below.

Program Choice: _____ Tuition Rate: _____ Date: _____

Program Choice: _____ Tuition Rate: _____ Date: _____

Program Choice: _____ Tuition Rate: _____ Date: _____

First Day of Care: _____

I agree to follow the above specified schedule for my child unless notice of schedule changes is provided. If there is a variation in my child's weekly schedule, communication will be provided prior to the week beginning. I agree to pay the above specified tuition for my child each Friday by 5:00PM. I agree to the above specified tuition rate and understand that payment secures my child's position in care and is not based on my child's attendance at the Community Center of Hope. I understand that tuition rates for each age group are subject to change prior to the "next tuition rate" date specified above. In the event of rate changes, notice will be provided, and an updated agreement will be signed. I acknowledge that I have received, read, and understand the Community Center of Hope Family Handbook and agree to all terms of the handbook.

_____

PARENT/LEGAL GUARDIAN SIGNATURE **DATE**

_____

DIRECTOR SIGNATURE **DATE**

COMMUNITY
CENTER of HOPE

FAMILY INFORMATION FORM

Child's Full Name: _____ **Date of Birth:** _____

MOTHER/GUARDIAN

First Name/M.I./Last Name: _____ Gender: ☐ M ☐ F

Address: _____ City: _____ Zip Code: _____

Occupation: _____ Home/Cell Phone: _____

Employer: _____ Work Phone: _____

Work Address: _____ Work Hours/Days: _____

E-Mail: _____ (required for communication)

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

FATHER/GUARDIAN

First Name/M.I./Last Name: _____ Gender: ☐ M ☐ F

Address: _____ City: _____ Zip Code: _____

Occupation: _____ Home/Cell Phone: _____

Employer: _____ Work Phone: _____

Work Address: _____ Work Hours/Days: _____

E-Mail: _____ (required for communication)

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

COMMUNITY
CENTER of HOPE

CHILD INFORMATION FORM

Child's Full Name: _____ Prefers to be called: _____

DOB: ____/____/____ Gender: ☐M ☐F Ethnicity: _____ Primary Language: _____

Address: _____ City/State/ZIP: _____

Mother/Legal Guardian: _____ Father/Legal Guardian: _____

Are both parents in the home? ☐Y ☐N If no, who does child live with? _____

Allergies: _____

Medications: _____

Names and ages of siblings: _____

Names and ages of additional children in the home: _____

Names of all people who live in your home and their relationships to your child: _____

_____

List any family pets (please identify species and names): _____

GETTING TO KNOW YOUR CHILD

Please answer all questions with honesty. It is important that the educators know what your child's needs are, so that they can ensure that they will receive the best care. For more space, write the correlating number of each question on the back of this form and continue your answer. Provide any information that would be helpful to your child's teacher.

1. Has your child ever been in group care? _____

2. Has your child played well with others in the past? _____

3. Does your child prefer playing alone or with others? _____

4. How does your child respond in group situations? _____

5. What activities engage your child the most at home? _____

_____

6. How does your child express anger, fear, and frustration? _____

_____

7. When your child is upset, what comforts them? _____

8. How do you address undesired behavior? _____

_____

9. What are your child's napping/night time sleeping habits? _____

_____

10. What time does your child fall asleep and awake on a regular day at home? _____

11. Does your child sleep with an item for security? Will you be providing something for security? _____

_____

12. Is your child potty trained/training? If so, explain the progress: _____

_____

13. What cues does your child use when they need to potty? _____

14. What is your child's eating habits like? _____

_____

15. What foods do they like/dislike? _____

_____

16. Are there foods/drinks you prefer your child not eat? _____

_____

17. How would you describe your child's temperament? _____

_____

18. Does your child take a pacifier over the age of 2? _____

19. Does your child see a therapist? If so, please explain: _____

_____

20. Are there any special family situations you would like to share to help better understand your child? _____

_____

21. Please list any likes/dislikes that your child has (i.e. environment, behavior, sounds, animals, etc.) _____

_____

22. What do you hope your child will gain from their experience in the environment? _____

_____

23. What are your expectations for your child? _____

_____

24. Does your child have special rights (also known as "special needs"? If so, elaborate on their situation: _____

_____

_____

25. Do you have concerns about your child adjusting? _____

_____

_____

26. Does your child have any disorders or developmental delays that may have a possible impact on their everyday play, learning, and/or growth? _____

_____

27. What holidays/traditions does your family celebrate? _____

_____

28. Are there any family celebrations, talents, or hobbies that your child or family would possibly like to share with us in the future? _____

29. List any resources, people, or locations of your child or family's interest that you feel would enrich programming at the Community Center of Hope: _____

_____

30. Is there anything else you would like us to know? _____

_____

COMMUNITY
CENTER of HOPE

EMERGENCY MEDICAL AUTHORIZATION FORM

I understand, and by my signature give consent, that in the event of serious accident, injury, or illness, my child will be given emergency medical care. I understand that 911 may be called and I will be contacted immediately following, or as soon as possible, depending on the state of the emergency. If immediate intervention is required, I understand that the educators are certified in infant, child, and adult CPR and First Aid, and will take appropriate action in stabilizing my child while waiting for Emergency Medical Services to arrive. If the parent(s)/legal guardian(s) cannot be reached with ONE phone call, the educators of the Community Center of Hope will call provided emergency contacts in the order they are listed. I also understand that my child's primary care physician may be contacted. Should my child need to be transported to the hospital by ambulance, I understand that the educators of the Community Center of Hope may accompany them and will stay with them until I arrive. I understand that if my child needs to be taken to a hospital immediately, they will be treated at the nearest hospital to the Community Center of Hope.

The nearest hospital to the Community Center of Hope is Columbus Regional Hospital, located at 2400. E. 17th Street, Columbus, IN, 47201.

I understand that if my child is injured in a non-life-threatening way, the educators will assess the child and provide basic first aid, notifying parents at pick-up.

Child's Full Name: _____ **Date of Birth:** _____

Last Four Digits of Child's SSN: ____-____-____-____

Child's Primary Care Physician: _____ Phone: _____

Address/City/State/ZIP: _____

Child's Primary Dentist: _____ Phone: _____

Address/City/State/ZIP: _____

Please list the primary hospital you take your child to receive care: _____

Health Insurance Provider: _____ Policy #: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Policy Holder Phone: _____

OR Medicaid ID # of child: _____

REMINDER: PLEASE UPDATE THIS FORM WHEN ANY CHANGES OCCUR.

_____

PARENT/LEGAL GUARDIAN SIGNATURE **DATE**

COMMUNITY
CENTER of HOPE

EMERGENCY CONTACT FORM

Child's Full Name: _____ **Date of Birth:** _____

If parent(s)/guardian(s) cannot be reached, at least ONE alternate contact is needed for your child. Any individuals listed may be asked to pick your child up from the Community Center of Hope in the event of an illness, injury, or emergency. List contacts in the order you wish for them to be contacted in. Please make alternate contacts local—within 30 to 40 minutes of facility. Contacts should be prepared to show a state issued I.D. Please copy this form if you need to add more contacts.

1. Name: _____ Relationship to Child: _____

Address/City/State/ZIP: _____

Phone: _____ □ Home/Cell □ Work Phone: _____ □ Home/Cell □ Work

2. Name: _____ Relationship to Child: _____

Address/City/State/ZIP: _____

Phone: _____ □ Home/Cell □ Work Phone: _____ □ Home/Cell □ Work

3. Name: _____ Relationship to Child: _____

Address/City/State/ZIP: _____

Phone: _____ □ Home/Cell □ Work Phone: _____ □ Home/Cell □ Work

4. Name: _____ Relationship to Child: _____

Address/City/State/ZIP: _____

Phone: _____ □ Home/Cell □ Work Phone: _____ □ Home/Cell □ Work

5. Name: _____ Relationship to Child: _____

Address/City/State/ZIP: _____

Phone: _____ □ Home/Cell □ Work Phone: _____ □ Home/Cell □ Work

I understand that the above listed person(s) will be contacted if I cannot be reached for reasons such as illness and emergency. I agree that the above person(s) understand that they are an emergency contact for the above-named child and the responsibilities this position renders.

_____

PARENT/LEGAL GUARDIAN SIGNATURE **DATE**

COMMUNITY
CENTER of HOPE

AUTHORIZATION TO PICK-UP FORM

Child's Full Name: _____ Date of Birth: _____

The below listed person(s) are authorized to pick up your child from the Community Center of Hope. Contacts should be prepared to show a state issued I.D. at pick-up. Please copy this form if you need to add more contacts.

1. Name: _____ Relationship to Child: _____

Address/City/State/ZIP: _____

Phone: _____ □ Home/Cell □ Work Phone: _____ □ Home/Cell □ Work

2. Name: _____ Relationship to Child: _____

Address/City/State/ZIP: _____

Phone: _____ □ Home/Cell □ Work Phone: _____ □ Home/Cell □ Work

3. Name: _____ Relationship to Child: _____

Address/City/State/ZIP: _____

Phone: _____ □ Home/Cell □ Work Phone: _____ □ Home/Cell □ Work

4. Name: _____ Relationship to Child: _____

Address/City/State/ZIP: _____

Phone: _____ □ Home/Cell □ Work Phone: _____ □ Home/Cell □ Work

5. Name: _____ Relationship to Child: _____

Address/City/State/ZIP: _____

Phone: _____ □ Home/Cell □ Work Phone: _____ □ Home/Cell □ Work

_____

PARENT/LEGAL GUARDIAN SIGNATURE **DATE**

COMMUNITY
CENTER of HOPE

DAILY CONSENT FORM

Child's Name: _____ **Date:** _____

PHOTO AND VIDEO RELEASE
I agree to allow the Community Center of Hope utilize photos/videos taken of my child while in the program or on a field trip for business purposes. I release photos/videos of my child in advance to be utilized in the following way(s):

- Business Website
- Business Social Media Pages
- Tend.ly App

WALKING FIELD TRIP
I agree to allow my child to participate in group walks within one mile of the Community Center of Hope under the direct supervision of educators. I understand that proper measures will always be taken to keep all children safe and together and an emergency kit and phone will be taken on each walk.

APPLY SUNSCREEN & BUG REPELLENT
I agree to allow application of sunscreen/bug repellent to my child's exposed skin during outdoor play. I understand that I am required to provide these items and the sunscreen must be rated for children.

WATER PLAY
I agree to allow my child to participate in supervised water play activities including, but not limited to play with sprinklers, water buckets, table streams, and sensory tables. This does NOT include swimming in a pool. All water play will meet Indiana state child care licensing regulations.

TRANSPORTATION
I agree to allow my child to be transported by Community Center of Hope educators for field trips and other off-site activities. Families will be notified when someone other than an educator will be needed to transport, and consent will be required at that time. Anyone providing transportation will possess a valid Indiana driver's license and have verified car insurance.

RIDE BIKES
I agree to allow my child to ride an age appropriate bike during outdoor play under direct supervision.

Please understand that not releasing consent for some subjects listed above could result in restricting your child from certain experiences. No child will be directly left out of an activity, so your child may need to be picked up from care if they cannot participate in a group activity.

PARENT/LEGAL GUARDIAN SIGNATURE **DATE**

COMMUNITY
CENTER of HOPE

GUIDANCE POLICY

Young children need a safe, positive, and consistent environment. To provide this for all children, the following guidance policy has been set in place and will be followed. When prevention strategies are used within the setting, there will be fewer disputes and conflicts.

The following are problem prevention strategies that are used in the setting:

- Educators keep expectations for the behavior developmentally appropriate.
- There are many choices for exploration available.
- Educators set clear limits for children's behavior.
- A consistent, yet flexible daily routine is established.
- Educators model respectful ways of interacting with others and using materials.
- Educators plan for daily transitions.
- Educators encourage and model "I" statements.

If a dispute or conflict arises, educators will use the following conflict resolution steps:

- Approach the situation calmly.
- Acknowledge the feelings of all children.
- Gather information about the conflict.
- Ask for ideas for solutions and provide options.
- Provide follow-up support for children involved.

The use of physical punishment or shaming is not permitted in our program. Time for reflection will be provided for children needing a break from a specific situation.

PARENT/LEGAL GUARDIAN SIGNATURE **DATE**

COMMUNITY
CENTER of HOPE

DRUG AND ALCOHOL POLICY

In effort to maintain a safe and healthy environment for children and families, a drug and alcohol policy has been established. The use of drugs, tobacco, alcohol, or potentially toxic substances used for purposes other than those intended by the manufacturer are prohibited on the Community Center of Hope property. It is expected that the educators, visitors, volunteers, and families adhere to this policy.

Please understand that the below rules will be enforced:

- Smoking in vehicles on the property is prohibited.
- The disposal of tobacco and alcohol products on or inside the property is prohibited.
- A child will NOT be released to any person designated to pick up the child if they appear to be under the influence of alcohol or drugs.
- There will NOT be a designated area for smoking on the property.

Families that do not adhere to this policy and its rules will be subject to termination or prevented from further drop-off and pick-up. Visitors that do not adhere to this policy and its rules will be subject to being banned from the property. Educators that do not adhere to this policy and its rules will be terminated. In certain situations, non-compliance with this policy could result in contacting authorities.

PARENT/LEGAL GUARDIAN SIGNATURE **DATE**

COMMUNITY
CENTER of HOPE

SAFE SLEEP POLICY

What is SIDS?
SIDS is a term used to describe the sudden, unexplained death of an infant. SIDS, an acronym that stands for Sudden Infant Death Syndrome, is the sudden and unexplained death of a baby under one year of age. Because many SIDS babies are found in their cribs, some people call SIDS "crib death;" but cribs do not cause SIDS.

What Is Known About SIDS

- SIDS is the leading cause of death in babies after one month to 12 months of age.
- Most SIDS deaths occur in babies who are between 2 and 4 months old.
- More SIDS deaths occur in colder months.
- Babies placed to sleep on their stomachs are much more likely to die of SIDS than babies placed on their backs to sleep.
- African American babies are twice as likely to die of SIDS as Caucasian babies.
- American Indian babies are nearly three times more likely to die of SIDS than Caucasian babies.
- In the United States, around 3,000 infant deaths are attributed to SIDS each year.

Approximately 20% of these deaths occurred while infants were in the care of someone other than their parent. In child care settings, the overriding risk factor for SIDS was placing a baby on his/her tummy to sleep. **Babies will be placed on their backs to sleep.**

Currently, SIDS is not preventable. However, the risks of SIDS and accidental suffocation and strangulation decrease with implementation of preventative guidelines. The following recommendations by the American Academy of Pediatrics and the National Back to Sleep Campaign will be applied in the childcare setting:

- **Place babies only on their backs to sleep.** This is the recommendation from the American Academy of Pediatrics and the National Back to Sleep Campaign applies to most babies. However, some babies should lie on their stomach (in a prone position), such as those with respiratory disease, symptomatic gastroesophageal reflux or certain upper airway malformations. Families are required to provide a written recommendation from their health provider if they believe their baby should sleep on his/her stomach.
- **Don't smoke.** A smoke-free environment is provided for babies; parents who smoke are encouraged to quit. Research indicates that the risk of SIDS doubles among babies exposed to first AND second-hand cigarette smoke after birth and triples for those exposed both during pregnancy and after birth.
- **Use firm, flat mattresses in safety-approved cribs for babies' sleep.** Soft sleeping surfaces and objects that trap gas in the babies' sleeping area will not be used. The U.S. Consumer Product Safety Commission has issued advisories for parents on the hazards to infants of sleeping on beanbag cushions, sheepskins, foam pads, foam sofa cushions, waterbeds, synthetic-filled adult pillows and foam pads covered with comforters.
- **Avoid overheating.** Overheating (too much clothing, too heavy bedding, and too warm a room) may increase the risk of SIDS for babies. The risk is reduced by more than 40% by utilizing the information above.

Safety Implementation
For infants less than 12 months of age, these practices will be followed to prevent suffocation:

- Babies will be placed on their back in a crib with a firm, tight-fitting mattress
- No pillows, quilts, comforters, pillow-like bumper pads, or pillow-like stuffed will be used
- If a fitted bottom sheet is used, it will be made specifically for crib use
- A warm sleeper or sleep sack will be used in place of a blanket
- Cribs will only be used if approved by the CPSC for safety
- The environment will remain smoke free always
- Children will sleep in a room between 68-74°F

I have read and understand this policy regarding the safe sleep of children under the age of 12 months. If I request any other position for sleeping other than my child's back, I understand that my child's physician must provide a note.

PARENT/LEGAL GUARDIAN SIGNATURE **DATE**

HEALTH CARE PROGRAM FOR CHILD CARE CENTERS
CHILD CARE CENTER HEALTH RECORD

State Form 49969 (R4 / 2-15)

FSSA - MS02
402 WEST WASHINGTON STREET, RM W361
INDIANAPOLIS, IN 46204

Name of child (*last, first*)	Date of birth (*month, day, year*)	Date of admission (*month, day, year*)
Address (*number and street, city, state, and ZIP code*)		
Child lives with (*relationship*)	Name	Telephone number ( )

MEDICAL HISTORY			
Communicable Disease	**Month / Year**	**Condition**	**Explain if present**
		Allergies:	
		Handicapping conditions:	
Screenings	**Result / Date** (*month, day, year*)		
TB Risk / Symptom		Other:	
Developmental Screen			
Lead			

PHYSICAL EXAMINATION	
Date of exam (*month, day, year*)	Age of child
Skin	Heart
Lymphnodes	Lungs
Eyes	Abdomen
Ears	Genitalia
Nasopharynx	Skeleton
Teeth and Mouth	Other:

Note any unusual findings:

Does this child have any health condition that would be hazardous either to the child or to other children in a group setting as a result of participation in normal activities (*including sports*)?

☐ Yes ☐ No If Yes, what modification of normal activities would be necessary to protect the child and the child's classmates:

Have you prescribed any medications or special routines which should be included in the center's plans for this child's activities? Explain:

☐ Yes ☐ No

(*Over*)

HISTORY OF IMMUNIZATIONS AND TEST (*indicate month / day / year*)

	1	2	3	4	5
DTaP / DT					

	1	2	3	4
Hib				

	1	2	3	4	5
IPV (Polio)					

	1	2	3	4	5
* **Influenza (Flu)**					

	1	2
Measles Mumps Rubella (MMR)		

	1	2	3
Rotavirus (RGE)			

	1	2		
Varicella (Varivax)			**or Chicken Pox Disease**	Month / year

	1	2	3	4
Pneumococcal (PCV) (Prevnar)				

	1	2
HEP A		

	1	2	3
HBV (HEP B)			

* Recommended yearly.

Name of physician / nurse practitioner completing form (*please print*)	Telephone number ( )
Signature of physician / nurse practitioner	

ADDITIONAL NOTES AND INSTRUCTIONS

RECORD OF MEDICATION ORDER

State Form 49968 (R2 / 11-11)

BUREAU OF CHILD CARE
DIVISION OF FAMILY RESOURCES

All medications, medicinal products, physician's sample medications, and medicinal skin care products given or used at a child care center must include the exact name of medication, dosage to be given, time to be given and reason for use. (*If used for fever, the degree of temperature must be stated.*) A physician's order is valid for one year.

1. Name of child	Exact name of medication
Dosage to be given	Time to be given (*frequency*)
Reason for use:	
Signature of physician / nurse practitioner	Date (*month, day, year*)
2. Name of child	Exact name of medication
Dosage to be given	Time to be given (*frequency*)
Reason for use:	
Signature of physician / nurse practitioner	Date (*month, day, year*)
3. Name of child	Exact name of medication
Dosage to be given	Time to be given (*frequency*)
Reason for use:	
Signature of physician / nurse practitioner	Date (*month, day, year*)
4. Name of child	Exact name of medication
Dosage to be given	Time to be given (*frequency*)
Reason for use:	
Signature of physician / nurse practitioner	Date (*month, day, year*)
5. Name of child	Exact name of medication
Dosage to be given	Time to be given (*frequency*)
Reason for use:	
Signature of physician / nurse practitioner	Date (*month, day, year*)

LICENSED CHILD CARE CENTER / HOME CONSENT

State Form 50548 (R2 / 7-06) / BCC 0080

To: Parents of licensed child care programs in Indiana

Subject: Your child's birth certificate and licensed child care programs

Indiana Code 12-17.2-2-1(8) requires each child care center or child care home to record proof of a child's date of birth before accepting the child for care. A child's date of birth may be proven by the child's original birth certificate or other reliable proof of the child's date of birth, including a duly attested transcript of a birth certificate. Refusing to share this information may result in your child's exclusion from a licensed child care program. Sharing the birth certificate information is NOT optional; signing the below is your decision and does not impact your use of child care facilities.

tear here

LICENSED CHILD CARE CENTER / HOME CONSENT

State Form 50548 (R2 / 4-06) / BCC 0080

This portion is to be kept on file at the licensed child care program.

I give my permission for Community Center of Hope, Inc. to report the name and date of birth

name of licensed child care program

of my child or children to the Division of Family Resources pursuant to IC 12-17.2-2-1.5.

Name of child	Date of birth (*month, day, year*)
Name of child	Date of birth (*month, day, year*)
Name of child	Date of birth (*month, day, year*)
Name of child	Date of birth (*month, day, year*)

Signature of parent, guardian, or custodian	Date signed (*month, day, year*)

BREAST MILK PROCEDURE

State Form 49954 (R5 / 3-15)

FSSA - MS02
402 WEST WASHINGTON STREET, RM W361
INDIANAPOLIS, IN 46204

Breast milk is a very special product. Provide a safe and excellent source of nutrition to your breast-fed infants by following the procedure below:

1. The facility or the mother must supply sterilized bottles or disposable nurser bags (*see "Parent Agreement"*).

2. The mother will store her milk in a bottle or bag and refrigerate or freeze the milk. The bottle or bag should contain no more than the amount of milk the child would drink at one feeding. The milk must be labeled with the child's name and the date and time collected.

3. The bottles or disposable bags must be brought to the center in a clean, insulated container which keeps the milk at 41° F or below (*see "Parent Agreement"*).

4. Fresh, refrigerated breast milk must be used within forty-eight (48) hours of the time expressed. Frozen milk may be stored in a refrigerator freezer for three (3) to six (6) months or stored in a deep freezer at -4° F for six (6) to twelve (12) months.

5. Frozen breast milk may be thawed as follows:

   (a) Frozen breast milk may be thawed under warm water, gently swirled, used within one (1) hour or refrigerated immediately and used within twenty-four (24) hours. Label the bottle with the time and date thawed and method used for thawing (*"warm water" or "heat thaw"*).

   (b) Frozen breast milk may be thawed in the refrigerator at 41° F or below. Label the bottle with the time and date moved to the refrigerator and "cold thaw" method and use within twenty-four (24) hours. With this method, **never warm** the breast milk until ready to feed the child.

   (c) Do not refreeze the breast milk once it has been thawed.

NEVER HEAT BREAST MILK IN A MICROWAVE!

Note: Once a bottle is fed to infant, the remainder **must be discarded** and cannot be returned to the refrigerator.

PARENT AGREEMENT

I, _____, agree to provide my breast milk for my child _____ in sterilized bottles or sterile nurser bags. I will store my milk in the appropriate serving size for my child. I take full responsibility for maintaining this milk at 41° F or below during home storage and transport to the center.

Signature of parent	Date (*month, day, year*)