LITTLE FLOCK NURSERY & PRESCHOOL

A safe, Secure, and Loving Atmosphere

SONLIGHT
AFTERCARE & DAY CAMP
ADMISSION FORM

Parents/Guardians: This information is required prior to your child's first day of attendance.

Age at time of enrollment:_____ Grade at time of enrollment:_____

Anticipated first day of attendance:_____ Last day child attended:_____

List the days and hours the child will be attending: _____

CHILD INFORMATION

Child's Full Name: _____ Birth Date: _____

Home Address: _____ Home Phone: _____

Home Language: _____

☐ Child Receives Non-Recurring Services

PARENT INFORMATION

Parent/Guardian 1 Full Name: _____ Employer: _____

Parent/Guardian Address (if different): _____

Email Address: _____

Parent/Guardian Phone: _____ Other Contact Phone: _____

Parent/Guardian 2 Full Name: _____ Employer: _____

Parent/Guardian Address (if different): _____

Email Address: _____

Parent/Guardian Phone: _____ Other Contact Phone: _____

☐ Court Order in Effect for: _____

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EMERGENCY CONTACTS

If neither parent can be reached in case of an emergency, call:

Name: _____ Phone: _____

Address: _____ Relationship: _____

Name: _____ Phone: _____

Address: _____ Relationship: _____

AUTHORIZED PICK UP

List all individuals who are authorized to pick up your child:

_____

_____

MEDICAL CONTACTS

Name of Child's Doctor: _____ Phone: _____

Name of Child's Dentist: _____ Phone: _____

Hospital Preference: _____

☐ Child's well-care exam documentation

☐ Child's immunization record

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ADDITIONAL INFORMATION ABOUT YOUR CHILD

Please describe any additional information you would like us to know about your child. This could include special medical, developmental, emotional or education needs, allergies, existing illnesses or injuries, previous serious illnesses or injuries and any prescribed medication including those for emergency situations.

_____
_____
_____
_____

Please list and provide a copy of any necessary documentation concerning your child - for example an IEP or CIS One Plan).

_____
_____
_____
_____

This information is accurate to the best of my knowledge.

_____ _____

(Parent/Guardian Signature) Date

_____ _____

LFNP Representative Signature Date

Permission to Participate

Please initial next to each statement:

_____ I/We give permission for my/our child to have photos taken and recognize those photos may be used for any legal purpose, including but not limited to: yearbook, publicity, copyright purposes, illustration, advertising and web purpose.

_____ I/We give permission for my/our child to participate in activities/recess that take place under the direct supervision of LFN staff. This includes, but is not limited to: cafeteria, playground and field, Collins Hall Gym or activities on the property of Websterville Baptist Church.

_____ I/We give permission to print my/our child's immunization records from the Vermont Immunization Registry.

_____ _____ _____

Child's Name Parent Signature Date

LFNP Representative Signature:_____ Date: _____

Sonlight Program
Medication and Medical Authorization:

Child's Name: _____ Child's DOB:_____

Medical Contacts:

Student's Physician: _____ Phone #: _____

Student's Dentist: _____ Phone #_____

Hospital Preference:_____ Phone #:_____

Medications:

I/We give permission for Little Flock Nursery staff to give our child the following (please check individually)

_____ Triple Antibiotic Ointment

_____ Insect Repellant

_____ Hydrocortisone/Anti-Itch Cream

_____ Diaper Cream

_____ Tylenol

_____ Benadryl

_____ Ibuprofen

_____ Sunscreen

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Please initial next to each statement.

____ I/We, as parents/guardians, take full responsibility for any side effects that may be caused by the medications we are authorizing to be administered. We understand that Little Flock Nursery is only administering the medication at our request and will not be held responsible for any adverse reactions.

_____ I/We agree to allow the staff of LFN/WCA to seek emergency care for our child as needed.

Child's Name_____ DOB_____

Parent/Guardian's Signature: _____ Date: _____

Parent/Guardian's Signature:_____ Date: _____

LFNP Representative:_____ Date:_____

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Illness Policy

In a group setting such as ours, infections can spread rapidly. If your child seems sick and you're trying to decide whether to send him/her to school, please observe the following guidelines. A child with the symptoms listed below will be excluded from the LFN setting until the symptoms disappear or until otherwise directed by a medical professional:

__A temperature above 100 — If medication is necessary to keep down a fever, your child MUST remain at home.__ Children may return to preschool after being free of a fever (without the use of medication) for 24 hours.
* LFN policy is to take the temperature over the course of 30 minutes, using two different thermometers.
*A severe cough in which the child becomes red/blue in the face or produces a whooping or croup noise after each cough
* Diarrhea — Child must be free for 24 hours before returning
* Vomiting — Child must be free for 24 hours before returning
*A rash that is accompanied with fever or behavior change
*Conjunctivitis (pinkeye)
*Contagious or infectious diseases such as: Bronchitis, strep throat, measles (red or German), chicken pox, mumps, roseola, etc.
*Infestations such as lice or scabies
***Severe cold — Please remember that if your child has a thick colored discharge from the nose, it is considered an infection and the child should be kept at home**

If your child is too ill to participate in all activities, including outside play, then you child is too sick to be at the Songlight programs.

A CHILD MUST BE ON A MEDICATION FOR ANY OF THE ABOVE ILLNESSES, IF DEEMED NECESSARY, FOR AT LEAST 24 HOURS AND/OR BE MEDICALLY IMPROVED BEFORE RETURNING TO THE PROGRAM.

If your child develops a fever or other symptoms during the school day, you (or your emergency contacts, in the event you cannot be reached) will be called and asked that your child be taken home in a timely manner.

Parents are asked to call 802-479-0142, email, or message your child's teacher in the morning if your child will be absent.

Medication

All medications (prescription and over-the-counter) must be sent to Sonlight program administrators in their ***original container***. A signed and dated permission slip complete with dosage instructions is also necessary. For a *Permission to Administer Medication Form*, please see the program director.

If your child develops a fever or other symptoms during the school day, you (or your emergency contacts, in the event you cannot be reached) will be called and asked that your child be taken home in a timely manner.

We the parents and/or guardians of _____(child's name) have read and understand the ***Illness Policy*** *of Little Flock Nursery and Preschool.*

_____*Parent/Guardian 1's Signature*

_____*Parent/Guardian 2's Signature*

DATE: _____

Ninety Day Probationary Period Notice

The first 90 days in one of the Sonlight programs are considered a trial period and care can be terminated at any time during those first 90 days by either party.

Parents wishing to leave after the 90 day trial period are encouraged to give at least a 10 day written and dated notice to the provider. Payment will still be required during those final days.

After the 90 day period the director will give a 10 day notice before terminating care whenever possible. The director can terminate immediately without notice in the following circumstances

-Child exhibits out of control behavior and puts other children at risk

-Child is not adjusting to the environment and it is difficult for them or the other children

-Parent is a risk to teachers, other parents, or children in care.

-Parent is not respectful of teachers, other parents, or children in care.

-Director is unable to meet child's needs without hiring an assistant.

-Failure to complete required forms

-Failure to comply with policies in this handbook.

If parents breach any part of the contract or if there are consistent late payments, late pick ups, or if parents knowingly bring an ill child to school, care can be terminated immediately with no refund given.

This policy has been communicated to me.

_____

Parent Signature Date

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EMERGENCY CONTACT INFORMATION

STUDENT'S NAME_____(Please print)

Date of Birth_____

Home Address: _____

Home Phone Number:_____

Cell Phone Number:_____

Parent/Guardian Email Address:_____

Emergency Contact: Please list two people that can be contacted in the case of an emergency.

NAME: _____TELEPHONE: _____

NAME: _____TELEPHONE: _____

Approved to Pickup Student:

Allergies:_____

Medications:_____

Additional Information:

_____

_____

_____

Parent/Guardian 1 Signature:_____**Date:** _____

Parent/Guardian 2 Signature:_____**Date:** _____

CHILD CARE GENERAL HEALTH EXAMINATION FORM

(Please remove and take to your doctor's office.)

Note: *This form can be used for child care programs as required documentation of a child's general health examination. Other physical forms used by the health provider's office documenting the child's age appropriate well care exam and information regarding any health conditions and medications that may impact the care of the child in child care are also acceptable.*

Please note the health exam must have been within the last 12 months.

Child's Name: _____

Date of Birth: _____ Date of Last Exam: _____

___ This child has no health conditions or medications that impact enrollment in child care.

___ This child has a condition or medication that should be known by the child care provider:

_____

_____

_____

_____

_____

Health Care Provider Name: _____

Phone Number: _____ Email:_____

Health Care Provider Signature: _____

Date: _____

PO Box 1 143 **Church Hill Road, Websterville,** 05678 · Phone & Fax: (802) 479-0142 · WCAVT.ORG/LITTLE-FLOCK · *Licensed Child Care Center*