BAINBRIDGE CHILDREN'S CENTER 2024/2025

Bainbridge Island Child Care Centers Since 1974 Non-Profit Organization

ENROLLMENT AND PERMISSION TO PARTICIPATE IN CENTER ACTIVITIES

Child's Name _____ Date of Birth: _____ ☐M ☐F

Parents/Guardian's Name/s: _____ _____

Address: _____

Home Phone:(___) _____ Work: (___) _____ Cell: (___) _____

Email Address: _____

Enrollment Fees: ***NEW Students****:* Include a **$**60.00 non-refundable enrollment fee & a non-refundable deposit **equal to** ½ of one months' tuition **to be applied to the last months' tuition.**

Returning Students: Please include a **$**60.00 non-refundable annual enrollment fee for returning students. (The previous ½ months deposit is held, to be applied to the last months' tuition.)

$60.00 + **Deposit $**_____ **= Total $** _____

ONE FULL MONTHS' advance notice is required for cancellation.

Space is reserved upon receipt of payment. Enrollment priority is per Board of Directors' policies.

1. I grant permission for my child to use all of the program equipment and participate fully in all activities.
2. I grant permission for my child to leave the center premises under staff supervision for neighborhood walks/ trips. I will be notified in advance with details regarding field trips or if van/vehicle transportation is used.
3. Unless crossed out and initialed specifically, I grant permission for my child and his/her image and voice to be included in any and all**:**

- Certifications, evaluations, studies, projects connected with the Center's program**;**
- Center-related electronic images, photographs**,** or videos used for staff training/workshops, advertising**,** electronic presence and public relations (Facebook, BICCC website, etc.); and
- The Center Directory, which lists family name, child's name, address, phone number and e-mail.

4. **I have read & understood the fee schedule, policies & procedures outlined in the BI-Child Care Centers' Parent Handbook and the Disaster/Emergency Preparedness Plan, and been provided an opportunity to request clarification of these policies.**
5. **I have completed a current Emergency & Health Form and updated the Immunization Form for my child.**
6. **I agree to pay monthly tuition and fees due on the first of the month in which services are provided.**
7. **I agree to wash laundry two (2) times during the year & receive credit (2x$10) toward my Maintenance Fee.**
8. **I agree to provide a change of clothing, rest blanket & appropriate seasonal clothing for my child.**

   I understand that I may be liable for reimbursement for use of the center's clothing & bedding.
9. **I understand that registration is not complete until all necessary paperwork is turned in with the registration fee and any past due balances, if applicable, have been paid.**

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

Date Received:_____ Rec'd by:_____ Ck#_____ Amt:_ Schedule Sent:_____ Confirmation Rec'd:_____

Forms Complete-- Emergency:_____ Health History:_ Social History:_____ Immunizations:_____ FT:_____

Child's Name: _____

Birth Date: _____ **M☐ F☐** **Ethnicity** (optional) _____

1. **Check one** ☐***Returning*** Re-Start Date: _____

   ☐***New Enrollment*** Start Date: _____

2. **Check the days your child will attend:**

   ☐**Monday** ☐**Tuesday** ☐**Wednesday** ☐**Thursday** ☐**Friday**

   Approximate time of attendance:_____a.m. to_____p.m.

4. **Choose a Schedule:**

   ☐ **Full Time** (8-10 Hours per Day)

   ☐ **Three-Quarter** (7 Hours or less per Day)

   ☐ **Part Time (**Starts at 8:30 am. & Ends by 12:30 pm.)

5. **Will your child attend Kindergarten in September 2025?**

   ☐**Yes** or ☐**No**

Alternate schedules are available as space permits with permission of the Center Director.

Extended Care may be available at an additional charge of $7.50/hr as space permits when care beyond the regular schedule is needed.

Bainbridge Island Child Care Centers

EMERGENCY CONTACT INFORMATION **Please fill out both sides of this form completely!**

Child's Name: _____ Date of Birth: _____

Elementary School: _____ Grade: _____ Teacher: _____

Parent/Guardian's Name: _____ Email: _____

Address: _____

Home #:_____ Cell#:_____ Work #:_____

Employer: _____ Position/Occupation: _____

Parent/Guardian's Name: _____ Email: _____

Address: _____

Home #:_____ Cell#: _____ Work #:_____

Employer: _____ Position/Occupation: _____

In case of emergency, illness or injury, if the parent/s or guardian/s cannot be reached, the following persons may be contacted and sign my child in/out because of said emergency. The following persons (with valid I.D, and 18 or older) may pick up my child with written or verbal notification. I agree to provide notification in advance. (Be aware that children cannot leave without parent notification). Additional persons may be added to an emergency contact addendum sheet with full information.

EMERGENCY CONTACTS

1. Name: _____ Relation: _____

Address: _____ Home#: _____ Cell#: _____

2. Name: _____ Relation: _____

Address: _____ Home#: _____ Cell#: _____

3. Name: _____ Relation: _____

Address: _____ Home#: _____ Cell#: _____

In case of a natural disaster, local telephone lines may be out of commission. The following out-of-state person may be contacted in order to coordinate the well-being of my child.

1. Name: _____ Relation: _____

Address: _____ Home#: _____ Cell#: _____

CONSENT FOR EMERGENCY TREATMENT

Health Care Provider Information

Child's Name: _____

A. Physician's Name: _____

B. Medical Center or Clinic (Please Initial Your Provide Information)

1. Virginia Mason
380 Winslow Way E.
Bainbridge Island
206.842.5632

2. Group Health Cooperative
19379 7th Ave NE.
Poulsbo
1.800.719.9911

3. Bainbridge Pediatrics
1298 Grow Ave NW
Bainbridge Island
206.780.5437

4. The Doctor's Clinic
945 Hildebrand Ln.
Bainbridge Island
206.855.7700

Other/Name: _____
Address: _____
Phone#: _____

Dentist's Name: _____Phone#: _____

Address: _____

C. Medical Insurance: _____ Ins. #: _____

D. Dental Insurance: _____ Ins. #: _____

E. Date of last Tetanus (DTP) Immunization: _____

F. Allergies & Expected Symptoms: _____

_____

_____

G. Other Medical Information: _____

_____

_____

- I will notify BICCC of any medication my child is taking, prescription or otherwise.
- I grant permission for my child to receive first aid treatment by a qualified Bainbridge Island Child Care Centers staff member. In the event of an emergency beyond the capability of staff members, I grant permission for my child to be medically treated by Emergency Medical Technicians/Paramedics or transported to an emergency center for treatment.
- In the event that I cannot be contacted, I further consent to the medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed health care provider/emergency treatment center when deemed immediately necessary or advisable by the health care provider/emergency medical technician to safeguard my child's health.

Parent/Guardian Signature: _____ Date: _____

Bainbridge Island Child Care Centers

Preschool through School Age Non Profit Organization

Unlimited Child Pick-Up Permission Form

The following person/s may pick up my child, _____

at any time without my expresses or written prior notification.

The following person/s are listed on my Emergency Form or Emergency Form Addendum with complete information.

I verify that they are at least 18 years of age.

1. Name: _____ Relation: _____
2. Name: _____ Relation: _____
3. Name: _____ Relation: _____

I understand that I am completely responsible for the pick up of my child and whomever I designate on the unlimited child pick up form, including late charges, signature and all factors relating to pick up.

Anyone picking up my child must present a valid I.D., Military I.D. or a valid United States Passport.

I further acknowledge that I understand the BICCC child pick-up policy:

- **Persons on my emergency form can pick-up only with my verbal or written consent**
- **If I wish for someone this is not on the emergency form to pick up my child, I must give written consent**
- **If I wish to designate someone to pick up my child, without prior notification, I must have an Unlimited Child Pick-Up Permission form on file.**

I will not hold BICCC liable if someone I have listed on this form picks up my child, as I give them permission to pick-up my child at anytime.

I will cancel by written notification when I want to make changes to persons listed on this form.

Signature: _____ Date: _____

Staff Initial: _____ Copies: (3) (a) Child File, (b) Emergency Log Book & (c) Field Trip Binder

Bainbridge Island Child Care Centers

Child Health History Form

Child's Name: _____ Birthdate: _____

According to Washington State Department of Early Learning Licensing requires (WAC 170-295-7010-3 (a)) children enrolled in childcare must have an annual physical examination.

Date of child's last examination or last visit with health care provider: _____ Initials: _____
Can be updated and initialed next year:
Date of child's last examination or last visit with health care provider: _____ Initials: _____
Can be updated and initialed next year:
Date of child's last examination or last visit with health care provider: _____ Initials: _____
Can be updated and initialed next year:

Name of Physician giving the exam: _____

Is your child currently on any medication? ( ) No ( ) Yes

If yes, what medication and why?

Does your child have any allergies? ( ) No ( ) Yes

If yes, to what? What type of allergic reaction does s/he have? How is it treated?

Does your child have any chronic illnesses?

(Including asthma, ear aches, stomach aches, tonsillitis, etc.) ( ) No ( ) Yes

If yes, please explain:

Does your child have any life threatening medical condition that requires an individual health plan?

<u>If yes, an Individual Plan of Care must be filed and approved by the physician</u>.

What past illnesses has your child had and at what age?

Chicken Pox ( ) No ( ) Yes Age: _____
Scarlet Fever ( ) No ( ) Yes Age: _____
Diabetes ( ) No ( ) Yes Age: _____
Mumps ( ) No ( ) Yes Age: _____
Hepatitis ( ) No ( ) Yes Age: _____

Has your child been to the dentist?
( ) No ( ) Yes Date: _____
Has your child's vision been tested?
( ) No ( ) Yes Date: _____
Has your child's hearing been tested?
( ) No ( ) Yes Date: _____

Other concerns or things we should know about your child's health:

_____

_____

Bainbridge Island Child Care Centers

Family and Social History

BICCC staff wish to assist you and your child with a positive successful transition into our programs.

The purpose of this information is to assist in that process. Please N/A any question that do not apply.

Child's Name: _____ Date of Birth: _____

Please list members of the family unit the child lives with (including relationship and age of siblings): _____

_____

What pets does your child have at home? _____

What responsibilities does your child have at home? _____

_____

Has your child had previous group experience? ( ) No ( ) Yes

If yes, did your child enjoy that experience? ( ) No ( ) Yes

If no, why not? _____

What does your child like to do? _____

_____

What method(s) of discipline is/are used at home? _____

_____

Please note concerns unique to your child regarding:

Dietary Restrictions? _____

Sleeping Issues? _____

Fears? _____

Behavior Patterns? _____

Special Needs/Other? _____

For Younger Children (2 ½ -5 years) only:

Does your child need help with clothing? _____

Words used for urination? _____ Bowel movement? _____

Does your child have a special security item? Please describe: _____

_____

Certificate of Immunization Status (CIS)

For Kindergarten-12th Grade / Child Care Entry

Office Use Only:	
Reviewed by:	Date:
Signed Cert. of Exemption on file? ❑ Yes ❑ No	

Please print. See back for instructions on how to fill out this form or get it printed from the Washington Immunization Information System.

Child's Last Name: **First Name:** **Middle Initial:** **Birthdate** (MM/DD/YY)**:** **Sex:**

I give permission to my child's school to share immunization information with the Immunization Information System to help the school maintain my child's school record.

Parent/Guardian Signature Required **Date**

I certify that the information provided on this form is correct and verifiable.

Parent/Guardian Signature Required **Date**

♦ Required for School and Child Care/Preschool
● Required Only for Child Care/Preschool

	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY
Required Vaccines for School or Child Care Entry						
♦ **DTaP / DT** (Diphtheria, Tetanus, Pertussis)						
♦ **Tdap** (Tetanus, Diphtheria, Pertussis)						
♦ **Td** (Tetanus, Diphtheria)						
♦ **Hepatitis B** ❑ 2-dose schedule used between ages 11-15						
● **Hib** (*Haemophilus influenzae* type b)						
♦ **IPV / OPV** (Polio)						
♦ **MMR** (Measles, Mumps, Rubella)						
● **PCV / PPSV** (Pneumococcal)						
♦ **Varicella** (Chickenpox) ❑ History of disease verified by IIS						
Recommended Vaccines (Not Required for School or Child Care Entry)						
Flu (Influenza)						
Hepatitis A						
HPV (Human Papillomavirus)						
MCV / MPSV (Meningococcal)						
MenB (Meningococcal)						
Rotavirus						

Documentation of Disease Immunity

Healthcare provider use only

If the child named in this CIS has a history of Varicella (Chickenpox) or can show immunity by blood test (titer) it MUST be verified by a healthcare provider

I certify that the child named on this CIS has:

❑ a verified history of Varicella (Chickenpox).

❑ laboratory evidence of immunity (titer) to disease(s) marked below. **Lab report(s) for titers MUST also be attached.**

❑ Diphtheria	❑ Mumps	❑ Other:
❑ Hepatitis A	❑ Polio	_____
❑ Hepatitis B	❑ Rubella	_____
❑ Hib	❑ Tetanus	
❑ Measles	❑ Varicella	

Licensed healthcare provider signature (MD, DO, ND, PA, ARNP) Date

Printed Name

Instructions for completing the Certificate of Immunization Status (CIS): printing it from the Immunization Information System (IIS) or filling it in by hand.

To print with immunization information filled in: Ask if your healthcare provider's office enters immunizations into the WA Immunization Information System (Washington's statewide database). If they do, ask them to print the CIS from the IIS and your child's immunization information will fill in automatically. You can also print a CIS at home by signing up and logging into MyIR at https://wa.myir.net. **If your provider doesn't use the IIS, email or call the Department of Health to get a copy of your child's CIS: waiisrecords@doh.wa.gov or 1-866-397-0337.**

To fill out the form by hand:

#1 Print your child's name, birthdate, sex, and sign your name where indicated on page one.

#2 Vaccine information: Write the date of each vaccine dose received in the date columns (as MM/DD/YY). If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guides below to record each vaccine correctly. For example, record Pediarix under Diphtheria, Tetanus, Pertussis as **DTaP**, Hepatitis B as **Hep B**, and Polio as **IPV**.

#3 History of Varicella Disease: If your child had chickenpox (varicella) disease and not the vaccine, **a health care provider must verify chickenpox disease to meet school requirements**.

- ❑ If your healthcare provider can verify that your child had chickenpox, ask your provider to check the box in the Documentation of Disease Immunity section and sign the form.
- ❑ If school staff access the IIS and see verification that your child had chickenpox, they will check the box under Varicella in the vaccines section.

#4 Documentation of Disease Immunity: If your child can show positive immunity by blood test (titer) and has not had the vaccine, have your healthcare provider check the boxes for the appropriate disease in the Documentation of Disease Immunity box, and sign and date the form. **You must provide lab reports with this CIS**.

Reference guide for vaccine abbreviations in alphabetical order For updated list, visit https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf

Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus	Hep A	Hepatitis A	MCV / MCV4	Meningococcal Conjugate Vaccine	OPV	Oral Poliovirus Vaccine	Tdap	Tetanus, Diphtheria, acellular Pertussis
DTaP	Diphtheria, Tetanus, acellular Pertussis	Hep B	Hepatitis B	MenB	Meningococcal B	PCV / PCV7 / PCV13	Pneumococcal Conjugate Vaccine	VAR / VZV	Varicella
DTP	Diphtheria, Tetanus, Pertussis	Hib	*Haemophilus influenzae* type b	MPSV / MPSV4	Meningococcal Polysaccharide Vaccine	PPSV / PPV23	Pneumococcal Polysaccharide Vaccine		
Flu (IIV)	Influenza	HPV (2vHPV / 4vHPV / 9vHPV)	Human Papillomavirus	MMR	Measles, Mumps, Rubella	Rota (RV1 / RV5)	Rotavirus		
HBIG	Hepatitis B Immune Globulin	IPV	Inactivated Poliovirus Vaccine	MMRV	Measles, Mumps, Rubella with Varicella	Td	Tetanus, Diphtheria		

Reference guide for vaccine trade names in alphabetical order For updated list, visit https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB®	Hib	Fluarix®	Flu	Havrix®	Hep A	Menveo®	Meningococcal	Rotarix®	Rotavirus (RV1)
Adacel®	Tdap	Flucelvax®	Flu	Hiberix®	Hib	Pediarix®	DTaP + Hep B + IPV	RotaTeq®	Rotavirus (RV5)
Afluria®	Flu	FluLaval®	Flu	HibTITER®	Hib	PedvaxHIB®	Hib	Tenivac®	Td
Bexsero®	MenB	FluMist®	Flu	Ipol®	IPV	Pentacel®	DTaP + Hib + IPV	Trumenba®	MenB
Boostrix®	Tdap	Fluvirin®	Flu	Infanrix®	DTaP	Pneumovax®	PPSV	Twinrix®	Hep A + Hep B
Cervarix®	2vHPV	Fluzone®	Flu	Kinrix®	DTaP + IPV	Prevnar®	PCV	Vaqta®	Hep A
Daptacel®	DTaP	Gardasil®	4vHPV	Menactra®	MCV or MCV4	ProQuad®	MMR + Varicella	Varivax®	Varicella
Engerix-B®	Hep B	Gardasil® 9	9vHPV	Menomune®	MPSV4	Recombivax HB®	Hep B		

If you have a disability and need this document in another format, please call 1-800-525-0127 (TDD/TTY call 711).

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