# Application for Admission

Child's Name: _____

Sex: _____ Date of Birth: _____

Toilet Trained: ☐ YES ☐ NO Scheduled Start Date: ____/____/____

Form of Deposit: ☐ Cash ☐ Credit Card ☐ Check #: _____

| | Parent | Parent |
|---|---|---|
| Name: | | |
| Home Address: | | |
| City, State, Zip Code: | | |
| Phone #: | | |
| Cell #: | | |
| ***Email: | | |
| *Emergency Pick Up Name/Information: Phone #: | | |

** In case of emergency, the above individual is authorized by the parent(s) to pick up a child. The authorized individual MUST show I.D. prior to child being released.*

## Medical / Allergy Information

| List All Allergies Below: | List Any Pertinent Medical Conditions: |
|---|---|
| | |
| | |
| | |

**Does your child have any specific needs that we need to know about?**

**How did you learn about Steps to Success III ?**

**As a cooperative day care center, Steps to Success III relies and respects parent involvement. How do you see yourself involved at our school?**

**Please list the 3 most important qualities you look for in a day care center:**

1.

2.

3.

Parent Signature

Date

# Program Agreement Form

I, _____, parent/guardian of _____, agree to pay $_____ for my child's attendance at Steps To Success Daycare facility.

*** ***I also understand that any deposits given to secure my child(ren)'s seat is non-refundable unless a 3 month notice prior to the start date is provided to Steps To Success. Furthermore, should I decide to postpone my child's start date, I understand and acknowledge that a onetime allowance is permitted for a postponement and should we decide not to attend after the postponement is granted, our deposit is relinquished immediately as the 3 month notice policy will NOT apply (the 3 month refund policy ONLY applies to the initial start date selected).***

Payment is due by the 5th of each month or I am liable for $30.00 late fee. I understand that my child is permitted ONE (1) Vacation Week Credit (vacation time is considered 5 consecutive days and ***MAY*** include when Steps to Success is closed and non-operational for holidays or emergency closures) per year at no charge to me. In furtherance, I understand that my child is entitled to TWO (2) Sick Week Credits (5 consecutive school/OPERATIONAL days) per year for which I will be responsible for 50% of the tuition for that week ONLY. My year commences from the date that my child begins attending Steps to Success and will be construed as my official enrollment. I am aware that I may NOT rollover any unused sick / vacation days/credits into the following attending year. I am also aware that any credit for vacation or sick time is limited to ONLY ONE (1) week maximum per month. Sick / Vacation time is considered 5 consecutive days when Steps To Success is open and operational; hence, this excludes emergency closures. I am also aware that any credit for vacation or sick time is limited to ONLY ONE (1) week maximum per month. Please note, if you are vacationing in a "high risk COVID country," you MUST quarantine for 2 weeks upon your return. However, you will only receive a ONE (1) week credit as per this agreement providing that you still have a credit owed to you. No additional vacation credits will be applied.

Furthermore, if we are closed due to weather related conditions or events that are out of our control (i.e.: no electricity/heat, storm related disasters, floods) we are not liable and full tuition will be applied for that particular month ONLY. If we are closed due to any of the following unforeseen events below, in the first 5 days of closure, there will be no credit applied towards that month's tuition payment. In addition, we will ONLY provide credit for 50% of the remaining tuition paid for said month beyond the first 5 days. If we are closed beyond that month, you will not be required to pay tuition until our centers re-open:

1. Government forced shutdown
2. Department of Health Mandated Quarantine due to COVID cases
3. Pandemics
4. Force Majeure

In addition, it is our policy that if you remove your child for a given month(s) you are responsible for half of the month's tuition in order to hold your child's seat. The maximum amount of days your child is permitted to attend within the month that you have notified management of non-attendance is five (5). If you go beyond the five permissible days, you will be responsible for the entire month's tuition less any applicable vacation/sick credits that you may have available and have not exhausted in the last 12 months. If your child is out for 2 consecutive weeks and we are unable to reach you and/or you have not contacted us, your child's seat is subject to being forfeited.

Finally, Steps To Success LLC, and its agents reserve the right to terminate admission into said Day Care Facility if instances arise that can potentially be harmful or threatening to children attending the facility and/or staff/management performing their duties. Moreover, should a parent/guardian of an attending child constitute a threat, either mental or physical to any of the employees, management, or a child attending said Day Care Facility, management reserves the right to preclude admission. Additionally, in the event that your child requires special needs care that we will unfortunately be unable and/or qualified to provide and once we have exhausted all options at our Center, for the betterment of your child's care and development, we will terminate services and assist in any way possible in finding alternate care.

***PRICES ARE SUBJECT TO CHANGE***

| _____ | _____ | ____/____/____ |
|---|---|---|
| Guardian Signature | Staff Signature | Date |

# COVID-19 Waiver & Release of Liability

I, _____ (referred to as "Customer") am the parent or legal guardian of _____ (the "Child"), who desires to receive certain child care services for my Child (the "Services") to be provided by Steps to Success_____, a New York limited liability company with a location of _____ (the "Company").In consideration for and as a condition precedent for receiving the Services and for the Child and Customer Parties (as defined herein) being permitted on Company's property, Customer agrees to all the terms and conditions set forth in this Waiver and Release of Liability (this "Waiver and Release").

Customer is aware and understands that the novel coronavirus known as COVID19, has been declared a worldwide pandemic by the World Health Organization. While the Company has established certain preventative measures to attempt to assist in the prevention or reduction in the spread of COVID-19, including but not limited to those set forth on Exhibit A attached hereto (the "Protocols and Guidelines"), Customer acknowledges that no precautions including the Protocols and Guidelines can eliminate the risks of exposure to COVID-19 and that the Company cannot assure that Customer or Customer's Child, agents, guests, invitees, and other representatives (collectively, "Customer Parties") will not become infected with COVID-19 through contact with individuals providing or receiving the Services or other invitees onto Company's property where the Services are rendered.An inherent risk of exposure to COVID-19 exists whenever people interact with one another face-to-face; therefor ,receiving the Services could increase the Customer Parties' risk of contracting COVID-19.

Customer acknowledges the highly contagious nature of COVID-19 and acknowledges and agrees that Customer is knowingly and voluntarily receiving the Services with an express awareness of the danger involved to the Customer Parties. Additionally, Customer agrees to follow and comply with the Company Protocols and Guidelines as a condition to receiving the Services. By signing this Waiver and Release, Customer on behalf of Customer and the Child, voluntarily accepts and assumes any and all risks, whether caused by the negligence of the Company or any of its personnel, invitees or otherwise, of Customer Parties' exposure to or infection by COVID-19 and any and all risks that such exposure or infection may result in personal injury, illness, temporary or permanent disability, and/or death (collectively, "Injuries") of Customer Parties, their family members, and persons with whom any of the foregoing come in contact during or after Customer's receipt of the Services (collectively, "Customer Contacts").

Customer hereby expressly waives and releases any and all claims, now known or hereafter known, against the Company and its members, managers, officers, directors, employees, agents, advisors, affiliates, successors, and assigns (collectively, "Releasees"), on account of Injuries arising out of or

or attributable or related to any actual or potential exposure to COVID19 as a result of the Company's provision of the Services ("COVID-Related Claims"), whether such exposure arises out of the negligence of the Company or any Releasee or otherwise. Customer covenants not to make or bring any COVID-Related Claim against the Company or any other Releasee, and forever releases and discharges the Company and all other Releasees from liability under any such COVID-Related Claims.

Customer shall defend, indemnify, and hold harmless the Releasees from and against any and all liabilities, losses, damages, costs and expenses, including reasonable attorneys' fees, fees and the costs of enforcing any right to indemnification under this Waiver and Release, and the cost of pursuing any insurance providers, incurred by any Releasee, arising out of or resulting from any COVID-Related Claim brought against such Releasee by or on behalf of a Customer Party.

If any term or provision of this Waiver and Release is invalid, illegal, or unenforceable in any jurisdiction, such invalidity, illegality, or unenforceability shall not affect any other term or provision of this Waiver and Release or invalidate or render unenforceable such term or provision in any other jurisdiction and the affected provision shall be reformed so that the parties intent is enforced to the greatest extent permitted by law. This Waiver and Release is binding on and shall inure to the benefit of Customer and the Company and their respective successors and assigns. This Waiver and Release shall not be so construed as to limit or otherwise derogate from any rights and/or obligations pursuant to any other agreements by and between Customer and Company; provided, this Waiver and Release shall control and supersede all other agreements by and between Customer and Company with respect to any and all conflicting terms related to COVID-19. All matters arising out of or relating to this Waiver and Release shall be governed by and construed in accordance with, and enforced under, the internal laws of the State of New York. Any claim or cause of action arising under this Waiver and Release may be brought only in the state and federal courts located in Richmond County and/or the Eastern District of New York, and Customer hereby consents to the exclusive jurisdiction of such courts.

**BY SIGNING BELOW, CUSTOMER ACKNOWLEDGES THAT IT HAS READ AND FULLY UNDERSTOOD ALL OF THE TERMS OF THIS AGREEMENT AND THAT ITIS VOLUNTARILY GIVING UP SUBSTANTIAL LEGAL RIGHTS, INCLUDING THE RIGHT TO SUE THE COMPANY.**

| | |
|---|---|
| _____ | _____ |
| Child / Participant Name | Parent / Guardian Signature |
| ____/____/____ | _____ |
| Date | Parent / Guardian Printed Name |

# Permission for Outdoor Activities

The Provider, Steps to Success _____, and the staff of Steps to Success _____ may take my child _____ for any activities checked below as part of the Preschool Program:

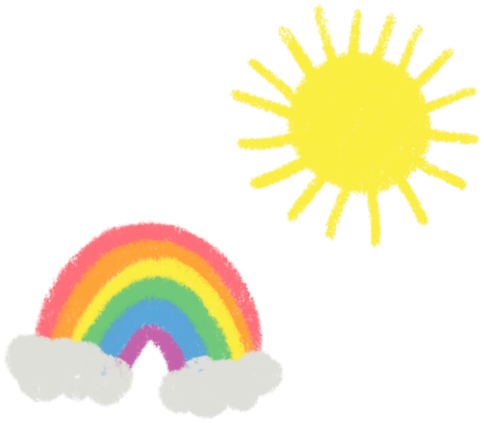
- ☐ On site playground
- ☐ Short walking trips

Parent Signature: _____

Address: _____

Phone Number: _____

Date: _____



# Photo Release Form

Dear Families,

Steps to Success III would like to request your permission in the use of your child's photo/picture for our facility's website and other forms of advertising.

Thank you,

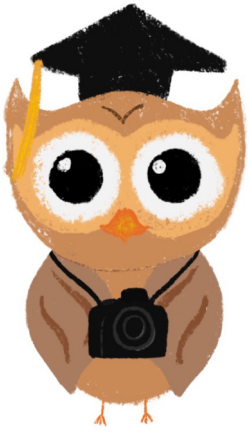
Management

◉ Yes, I agree to the terms above: _____

Parent Signature

○ No, I do not agree to the terms above: _____

Parent Signature



# CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

*Please Print Clearly Press Hard*

STUDENT ID NUMBER OSIS

## TO BE COMPLETED BY PARENT OR GUARDIAN

Child's Last Name | First Name | Middle Name | Sex ☐ Female ☐ Male | Date of Birth (Month/Day/Year) ___/___/___

Child's Address | Hispanic/Latino? ☐ Yes ☐ No | Race (Check ALL that apply) ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other

City/Borough | State | Zip Code | School/Center/Camp Name | District ___ Number ___ | Phone Numbers: Home, Cell, Work

Health Insurance (including Medicaid)? ☐ Yes ☐ No | ☐ Parent/Guardian ☐ Foster Parent | Last Name | First Name

## TO BE COMPLETED BY HEALTH CARE PROVIDER *If "yes" to any item, please explain (attach addendum, if needed)*

**Birth history** *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

**Allergies** ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* _____

☐ Foods *(list)* _____

☐ Other *(list)* _____

**Does the child/adolescent have a past or present medical history of the following?**

☐ Asthma *(check severity and attach MAP/Asthma Action Plan):* ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

*If persistent, check all current medication(s):* ☐ Inhaled corticosteriod ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

☐ Attention Deficit Hyperactivity Disorder
☐ Chronic or recurrent otitis media
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes *(attach MAP)*
☐ Orthopedic injury/disability
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Other *(specify)* _____

***Explain all checked items above or on addendum***

**Medications** *(attach MAP if in-school medication needed)*

☐ None ☐ Yes *(list below)*

_____

_____

**Dietary Restrictions**

☐ None ☐ Yes *(list below)*

_____

**PHYSICAL EXAMINATION**

Height _____ cm (___ %ile)

Weight _____ kg (___ %ile)

BMI _____ kg/m² (___ %ile)

Head Circumference *(age ≤2 yrs)* _____ cm (___ %ile)

Blood Pressure *(age ≥3 yrs)* _____ / _____

**General Appearance:**

| Nl | Abnl | | Nl | Abnl | | Nl | Abnl | | Nl | Abnl | | Nl | Abnl | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | HEENT | ☐ | ☐ | Lymph nodes | ☐ | ☐ | Abdomen | ☐ | ☐ | Skin | ☐ | ☐ | Psychosocial Development |
| ☐ | ☐ | Dental | ☐ | ☐ | Lungs | ☐ | ☐ | Genitourinary | ☐ | ☐ | Neurological | ☐ | ☐ | Language |
| ☐ | ☐ | Neck | ☐ | ☐ | Cardiovascular | ☐ | ☐ | Extremities | ☐ | ☐ | Back/spine | ☐ | ☐ | Behavioral |

**Describe abnormalities:**

**DEVELOPMENTAL** *(age 0-6 yrs)* ☐ Within normal limits

If delay suspected, specify below

☐ Cognitive *(e.g., play skills)* _____

☐ Communication/Language _____

☐ Social/Emotional _____

☐ Adaptive/Self-Help _____

☐ Motor _____

| SCREENING TESTS | Date Done | Results |
|---|---|---|
| **Blood Lead Level (BLL)** *(required at age 1 yr and 2 yrs and for those at risk)* | ___/___/___<br>___/___/___ | _____ µg/dL<br>_____ µg/dL |
| **Lead Risk Assessment** *(annually, age 6 mo-6 yrs)* | ___/___/___ | ☐ At risk *(do BLL)*<br>☐ Not at risk |
| **Hearing**<br>☐ Pure tone audiometry<br>☐ OAE | ___/___/___ | ☐ Normal<br>☐ Abnormal |
| **Head Start Only** | | |
| **Hemoglobin or Hematocrit** *(age 9–12 mo)* | ___/___/___ | _____ g/dL<br>_____ % |

| | Date Done | Results |
|---|---|---|
| **Tuberculosis** *Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school* | | |
| PPD/Mantoux *placed* | ___/___/___ | Induration _____ mm |
| PPD/Mantoux *read* | ___/___/___ | ☐ Neg ☐ Pos |
| Interferon Test | ___/___/___ | ☐ Neg ☐ Pos |
| Chest x-ray *(if PPD or Interferon positive)* | ___/___/___ | ☐ Nl ☐ Abnl ☐ Not Indicated |
| **Vision** *(required for new school entrants and children age 4–7 yrs)* | ___/___/___ ☐ with glasses | Acuity *Right* ___/___ *Left* ___/___<br>Strabismus ☐ No ☐ Yes |

**IMMUNIZATIONS – DATES** CIR Number of Child

| | | | | |
|---|---|---|---|---|
| Hep B | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ |
| Rotavirus | ___/___/___ | ___/___/___ | ___/___/___ | |
| DTP/DTaP/DT | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ |
| | ___/___/___ | ___/___/___ | ___/___/___ | |
| Hib | ___/___/___ | ___/___/___ | ___/___/___ | |
| PCV | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ |
| Polio | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ |

| | | | |
|---|---|---|---|
| Influenza | ___/___/___ | ___/___/___ | ___/___/___ |
| MMR | ___/___/___ | ___/___/___ | ___/___/___ |
| Varicella | ___/___/___ | ___/___/___ | |
| Td | ___/___/___ | ___/___/___ | ___/___/___ |
| Tdap ___/___/___ | Hep A | ___/___/___ | ___/___/___ |
| Meningococcal | ___/___/___ | ___/___/___ | |
| HPV | ___/___/___ | ___/___/___ | ___/___/___ |
| Other, *specify:* _____ | ___/___/___; | _____ | ___/___/___ |

**RECOMMENDATIONS** ☐ Full physical activity ☐ Full diet

☐ Restrictions *(specify)* _____

**Follow-up Needed** ☐ No ☐ Yes, for _____ Appt. date: ___/___/___

**Referral(s):** ☐ None ☐ Early Intervention ☐ Special Education ☐ Dental ☐ Vision

☐ Other _____

**ASSESSMENT** ☐ Well Child (V20.2) ☐ Diagnoses/Problems *(list)* **ICD-9 Code**

_____ _____

_____ _____

_____ _____

Health Care Provider Signature | Date ___/___/___

Health Care Provider Name and Degree *(print)* | Provider License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone (___) ___-____ | Fax (___) ___-____

**DOHMH ONLY** PROVIDER I.D.

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

*Comments*

Date Reviewed: ___/___/___ I.D. NUMBER

REVIEWER:



*Copies:* White School/Child Care/Early Intervention/Camp, Canary Health Care Provider, Pink Parent/Guardian

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

# DAY CARE REGISTRATION

Child's Full Name:

Does your child have any allergies? Yes No

If Yes, what is your child allergic to?

Children who have special health care needs are those who have chronic physical, developmental, behavioral or emotional conditions expected to last 12 months or more and who also require health and related services of a type beyond that required by children generally. If your child does have special health care needs please discuss these with your child-care provider.

| Child's Source of Medical Care/Primary Care Physician's Name: | Telephone Number: |
|---|---|
| Child's Source of Dental Care/Dentist's Name: | Telephone Number: |
| Name Of Medical Care Facility/Hospital: | Telephone Number: |

Would you like information on Child Health Plus? Yes No

| | RELATIONSHIP | CONTACT NAME | TELEPHONE NUMBER DURING CHILD CARE | OTHER TELEPHONE NUMBER (Check type) |
|---|---|---|---|---|
| EMERGENCY DATA | | | | Pager Cell Other |
| | | | | Pager Cell Other |
| | | | | Pager Cell Other |
| | | | | Pager Cell Other |

| Provider/Day Care Facility Name and Address: | CHILD'S FULL NAME: | SEX: Male Female |
|---|---|---|
| | CHILD'S HOME ADDRESS: | DATE OF BIRTH:<br>HOME TELEPHONE NUMBER: |
| | DATE OF ACCEPTANCE: | DATE OF DISCHARGE: |
| | NAME OF PERSON APPLYING FOR CHILD: | Parent Guardian Caretaker Relative Other<br>HOME TELEPHONE NUMBER:<br>DAYTIME TELEPHONE NUMBER: |
| | ADDRESS OF PERSON LISTED ABOVE: (IF DIFFERENT FROM CHILD'S): | |

**AGREEMENTS**

I consent to the enrollment of the child listed above in this facility and have been advised of the policies regarding administration of medications, fees, transportation and the services provided by the facility, and the Office of Children and Family Services regulations under which it operates.

I give consent for my child to take part in neighborhood trips (i.e. library, park and playground) away from the facility under proper supervision. Yes No

In case of accident or injury, I authorize any and all emergency medical, dental, and /or surgical care and hospitalization advised by the physicians, surgeon or hospital (listed on the other side of this card) necessary for the proper health and well-being of my child. Yes No

I have provided information on my child's special needs (Allergies, Diet, Disabilities, and /or Medical Information) to the provider, as may be necessary to assist the facility in properly caring for my child in case of an emergency. Yes No

I agree to review and update this information whenever a change occurs and at least once every six months. Yes No

| SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE | DATE: |
|---|---|
| | |

**CENTER**

**NAME:**

**ADDRESS:**

**BORO:**

318K (REV. 4/12)

**NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**BUREAU OF CHILD CARE**

# DAY CARE CUMULATIVE HEALTH RECORD

Date of Admission ____/____/____

**TO BE COMPLETED BY PARENTS/GUARDIANS AND DAY CARE STAFF**

| | | | | |
|---|---|---|---|---|
| **NAME:** *(Last)* | *(First)* | *(Middle)* | **SEX** F ☐ M ☐ | **DATE OF BIRTH** Country/State of Birth |
| **ADDRESS:** *(No.)* | *(Street)* | *(City/Boro)* | *(State)* | *(Zip)* |
| **MOTHER'S NAME:** *(First)* | *(Last)* | **FATHER'S NAME:** *(First)* | *(Last)* | **TELEPHONE NO** Home: Work: |
| FOSTER PARENT | | | | |
| FOSTER AGENCY | | ADDRESS | | TELEPHONE # |
| LANGUAGE SPOKEN IN HOME | | | | |

**PERSON/S TO CONTACT IN CASE OF EMERGENCY** *(Other Than Parent)*

| | |
|---|---|
| **NAME** | **RELATIONSHIP TO CHILD** |
| **ADDRESS** | **TELEPHONE NO.** Home: Work: |

**NAME OF MEDICAL PROVIDER, CLINIC OR HOSPITAL**

| | | |
|---|---|---|
| **NAME** | **CONTACT PERSON** | **PATIENT NO.** |
| **ADDRESS** | | **TELEPHONE NO.** |

| **SIGNIFICANT FAMILY HISTORY** | | **IS CHILD ALLERGIC TO ANY:** |
|---|---|---|
| (____) Asthma | (____) Heart Disease | (____) Medications *(Specify)* |
| (____) Diabetes | (____) Hypertension | (____) None ____ |
| (____) Convulsive Disorder | (____) Tuberculosis | (____) Foods *(Specify)* ____ |
| (____) Allergies *(Specify)* | (____) Vision | (____) Insect Bites ____ |
| (____) OTHER *(Specify)* | (____) Hearing | (____) OTHER ____ |

| **HOSPITALIZATIONS AND ILLNESSES** | **YES** | **NO** | **EXPLAIN** |
|---|---|---|---|
| Has child ever been hospitalized or operated on? | | | |
| Has child ever had a serious accident (broken bone, head injury, fall, burns, poisoning)? | | | |
| Has child ever had a serious illness? | | | |

| **SPECIAL HEALTH CONDITIONS** | **AGE IT BEGAN** | **TREATMENT/MEDICATIONS** |
|---|---|---|
| (Long term or chronic) | | |
| 1. ____ | | |
| 2. ____ | | |
| 3. ____ | | |
| 4. ____ | | |
| 5. | | |

X I,____ hereby certify that information provided herein is complete and accurate.

**CONSENT FOR EMERGENCY MEDICAL TREATMENT** *(REQUIRED FOR ADMISSION TO DAY CARE)*

I do hereby give authority to the day care program staff to obtain necessary emergency medical treatment for my child, with the understanding that the family will be notified as soon as possible.

SIGNED ____ DATE ____ RELATIONSHIP ____

Subscribed and sworn to before me this ____ day of ____ 19 ____

Notary Public or Commissioner of Deeds (OPTIONAL) County of

# Pick Up Authorization

I (we), the parents of _____,
give my (our) consent for the following individual(s) to pick up my (our) child if I (we) are unable to do so.

| Name: | Address: | Phone #: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

The following individual(s) are not allowed to up my (our) child.

1. _____

2. _____

_____
Parent Signature:

_____
Provider Signature:

# Sleeping & Napping Arrangement

Sleeping and napping arrangements must be made in writing between the parent and the child care provider. The provider shall maintain this completed agreement on file in the child care home. This arrangement is required by New York State Child Day Care Regulations [Family Day Care 417.7(l) and 417.8(a)(1), and Group Family Day Care 416.7(l) and 416.8(a)(1)].

I, _____, understand that my child, _____,
(parent name) (child name)

while under the care of _____, will be napping on a
(child care provider or program name)

_____ in the _____ of the child care home.
(cot, mat, bed or crib) (area of home)

My napping child will have competent supervision at all times, either through:

(Check one box:)

☐ direct supervision by a caregiver who is in the same room and has direct visual contact with him/ her;

OR

☐ indirect supervision by a caregiver who uses a functioning electronic monitor and remains on the same floor as my child at all times. The doors to all rooms where children are napping must remain open, as well as the doors to all rooms used by the provider.

If my child is an infant, I also understand that my child will be placed on his/ her back to sleep.

Parent Signature: _____

Date (Month/ Day/ Year): _____

Child Care Provider Signature: _____

Date (Month/ Day/ Year): _____

# Things I Need for School !

***PLEASE LABEL ALL BELONGINGS!***

| Item | Done |
|---|---|
| 1. Sleeping Bag | |
| 2. Slippers | |
| 3. Change of Clothing | |
| 4. Diapers or Pull Ups *(where applicable)* | |
| 5. Wet Wipes | |
| 6. Bibs *(2-3 years old group)* | |
| 7. One Paper Towel (Bounty) Roll | |
| 8. Box of Tissues | |

Please **do not allow** your children to bring any toy items and/or candy of any sort to the day care facility. It can potentially cause conflict between the children and we strictly prohibit it. We thank you in advance for your attention and cooperation to this mater. We will notify you in advance if any other items will be needed for school.

Sincerely,

Management