



# Trinity Lutheran Child Development Center Child Registration Form

Date Child Entered Care \_\_\_\_\_

Child's Last Name	First Name	MI	GENDER	Birthdate
Street Address			City	Zip
Parent/Guardian Name	Cell ph#	Work ph#	Email	
Street Address			City	Zip
Parent/Guardian Name	Cell ph#	Work ph#	Email	
Street Address			City	Zip

### Other people to notify in case of emergency

Name	Address	Phone Numbers
Relationship:		Work Home Cell
Relationship:		Work Home Cell
Relationship:		Work Home Cell

### Other than the parent, who has permission to pick up child?

Name	Phone Numbers

### Child's Health Information

Date of Child's last physical exam	Name of Health Care Provider  Phone #	Name of Dentist  Phone #
Special Health Problems	Allergies, including drug reactions	
Regular medications	Other pertinent data	

### Consent to medical care and treatment of minor child

I hereby give permission that my child, \_\_\_\_\_, may be given treatment by a qualified child care provider at Trinity Lutheran Child Development Center. When I cannot be contacted, I authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital or emergency medical technician (EMT) when deemed necessary or advised by the physician or EMT to safeguard my child's health. I waive my right of informed consent to such treatment.

I also give permission for my child to be transported by ambulance or aid car to the nearest emergency center for treatment.

In the event of a non-life threatening emergency, my hospital of choice is:

Parent/Guardian Signature _____	Date _____	Parent/Guardian Signature _____	Date _____
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Child's Name:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate:	Today's Date:
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### Child's Health History

Name of Doctor/Clinic:	City/State:	Phone number:
Were there any significant problems during pregnancy or birth? <input type="checkbox"/> No <input type="checkbox"/> Yes, Please explain:		
Has your child had surgery or been hospitalized? <input type="checkbox"/> No <input type="checkbox"/> Yes, Please explain:		
Date last seen by a healthcare provider (for reasons other than immunizations):		

### Medication

Does your child take medication on a regular basis? <input type="checkbox"/> No <input type="checkbox"/> Yes, Reason:
Name of medication(s), dosage and when taken:

<b>Has your child had any of the following?</b>		<b>Age of child or date of incident ▼</b>
Asthma	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:
Other breathing problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:
Seizures or other neurological problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:
Heart or other cardiovascular problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:
Bladder or urinary tract problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:
Bowel or other GI problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:
Bone or joint problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:
Eczema or skin problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:
Frequent ear infections or tubes	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:
Other ear, nose or throat problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:
Tuberculosis exposure	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:
Chicken Pox or vaccination for such	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:
Diabetes or other endocrine problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:
Injury or abuse	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:
Car sickness	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:
Other describe:		

### Nutrition History

Is there any food or drink that your child should not eat for cultural, religious, personal reasons or medical reasons **other than allergies?** (Note: use the allergy chart on the next page to list any allergies to food or drink)

**Yes, list below**

**No, skip to next question**

Name or food/drink:	<input type="checkbox"/> Cultural	<input type="checkbox"/> Religious	<input type="checkbox"/> Personal	<input type="checkbox"/> Medical/describe:
	<input type="checkbox"/> Cultural	<input type="checkbox"/> Religious	<input type="checkbox"/> Personal	<input type="checkbox"/> Medical/describe:
	<input type="checkbox"/> Cultural	<input type="checkbox"/> Religious	<input type="checkbox"/> Personal	<input type="checkbox"/> Medical/describe:
	<input type="checkbox"/> Cultural	<input type="checkbox"/> Religious	<input type="checkbox"/> Personal	<input type="checkbox"/> Medical/describe:
Does your child have any problems with chewing or swallowing?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Please describe:		
Check the box if you have concerns about your child's:	<input type="checkbox"/> Eating habits	<input type="checkbox"/> Height	<input type="checkbox"/> Weight	
Please describe:				

### Allergy History

Does your child have allergies or reactions (including intolerances) to food, medicine, insects, animals or other substances?

**Yes, please complete chart below**

**No – Skip to Dental History below**

**Allergy Chart** Note: If your child has a food or milk allergy, we must have written documentation of the allergy from the doctor. For milk allergies, the doctor must also name a substitute for the milk.

Do you keep epinephrine (epi-pen) available at home for your child's allergy?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
List each allergy or food separately	Briefly describe child's reaction and/or check symptoms			Potential Severe Reaction*	Doctor/Date of Diagnosis
	<input type="checkbox"/> Hives	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Runny nose	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Hives	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Runny nose	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Hives	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Runny nose	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Hives	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Runny nose	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Hives	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Runny nose	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Hives	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Runny nose	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No

**\* If the allergy has the potential to be severe, the child's health care provider should complete a medical statement and an allergy care plan should be completed.**

Additional information about allergy:

### Dental History

Name of dentist:	Date last seen by dentist:	City/State:	Phone number:
How would you rate your child's dental health?	<input type="checkbox"/> Very good	<input type="checkbox"/> Somewhat good	<input type="checkbox"/> Fair <input type="checkbox"/> Somewhat bad <input type="checkbox"/> Very bad
Has your child ever had an injury to the teeth or gums?	<input type="checkbox"/>	<input type="checkbox"/> Yes, please explain:	
Has your child complained about pain in the teeth or gums?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Is there fluoride in the water at your home, or is your child taking a prescribed fluoride supplement?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

**Parental Concerns**

Do you have any concerns about your child's vision?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Please describe:
Do you have any concerns about your child's hearing?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Please describe:
Do you have any concerns about your child's speech?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Please describe:
Do you have any concerns about your child's behavior?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Please describe:
Do you have any concerns about your child's development?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Please describe:
Do you have any other concerns about your child?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Please describe:

Additional information regarding concerns:

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**Communicable Disease Outreach Program**

3020 Rucker Avenue, Suite 300 ■ Everett, WA 98201-3900 ■ fax: 425.339.8706 ■ tel: 425.339.5278



Trinity Lutheran Child Development Center  
A ministry of Trinity Lutheran Church  
6215 196<sup>th</sup> Street Southwest  
Lynnwood, Washington 98036  
(425) 771-5393

## Child Care Agreement

Start Date \_\_\_\_\_

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Please initial each line item**

\_\_\_\_\_ My child is scheduled to attend on the following days: M T W TH F

\_\_\_\_\_ I understand that upon registration a non-refundable \$30.00 Registration Fee & a \$30.00 Security Fee is due. This is a total of \$60.00 due that is separate from the tuition amount.

Tuition:

\_\_\_\_\_ Tuition of \_\_\_\_\_ is paid monthly through Brightwheel. Failure to pay tuition will result in termination of services.

\_\_\_\_\_ I have received and read the Parent Handbook.

\_\_\_\_\_ I understand that my child's space is reserved for them, therefore payment in full is required regardless of attendance unless written notice of withdrawal is given.

\_\_\_\_\_ I understand that the center is on modified hours during Covid from 8:00 AM to 5:00 PM. My child will not be permitted in the building before this time.

\_\_\_\_\_ I agree to pay a \$20.00 fee for any check returned NSF.

\_\_\_\_\_ I understand that the Center closes at 6:00 p.m. daily. I agree to pick up my child before that time. I understand a late pick-up fee of \$1.00 per minute will be assessed each minute after 6:02 p.m. This fee is payable to the staff member who stays late.

Parent  
Signature \_\_\_\_\_ Date \_\_\_\_\_



## BRIGHTWHEEL CONSENT FORM

Trinity Lutheran Child Development Center uses Brightwheel, a platform that significantly helps teachers manage their classrooms through an app to observe and track the children, communicate with families, and share photos and videos. Brightwheel will also manage our accounts and billing.

Brightwheel uses digital attendance and sign in, which requires all adults picking up children to have a four digit code to sign in and sign out the children. You need to provide the CDC office with your email address to receive an invite to sign up to Brightwheel. Once you create an account with the same email address that the school has on file, you should see your child's profile. Shortly thereafter you will begin receiving daily updates. Brightwheel is able to send daily updates on food menu items, activities, diaper changes, potty training and accident reports.

To begin using Brightwheel we need to have your permission for uploading photos, videos, learning stories and artwork involving your child on the Brightwheel platform. Please provide a current email address so we can send you an invitation to join Brightwheel.

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Child's Name \_\_\_\_\_

As the parent/guardian for the child named above, I consent to Trinity Lutheran Child Development Center's collection, use and display of my child's information on the Brightwheel application in accordance with the Privacy Policy set out on the Brightwheel website: <https://mybrightwheel.com/privacy/>

\_\_\_\_\_  
*Parent Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Parent printed name*

\_\_\_\_\_  
*Email address*

\_\_\_\_\_  
*Parent Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Parent printed name*

\_\_\_\_\_  
*Email address*

Child Care Facility Name:
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Parent/Guardian permission is required for all sunscreen application. Sunscreen products are applied to provide protection from the sun's UV rays. The child care follows these guidelines regarding sunscreen:

1. Acceptable sunscreens will be broad-spectrum with an SPF of 30 or higher.
2. Sunscreen will be applied 20-30 minutes before going outside, especially during the summer months and between 10 am and 4 pm.
3. Sunscreen will not be applied to children younger than 6 months without a doctor's note.
4. Parents are encouraged to send a hat with a wide brim for their child to wear outside.
5. Sunscreens will be stored at room temperature and out of reach of children.
6. Sunscreen product will be provided by:  parents  child care

**Please provide the following information:**

Child's Name:	
Date of Birth:	
Name of Sunscreen and SPF:	
Active Ingredient(s):	
Authorization Form Filled Out on:	Authorization Expires: <span style="float: right;">(6 months from start date)</span>
Comments or specific information (such as possible side effects, areas to avoid when applying sunscreen, etc.)	

**I authorize the use of the above sunscreen on my child. I understand that this sunscreen will be applied to exposed skin, which may include the face, ears, arms, shoulders, legs, and feet.**

Parent/Guardian Signature:	Date:
Daytime Phone Number:	

See back of form