Trinity Lutheran Child Development Center
A ministry of Trinity Lutheran Church
6215 196th 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.

_____I have received and read the Parent Handbook and Crisis/Disaster handbook.

_____I Understand that the center is open at 7:00am and Clients may not enter the building before then.

_____I understand that the Center closes at 6:00 pm daily. I understand that after 6:02 a late fee of $20 will be charged to my Brightwheel account in 15 minute increments (6:03-6:15 $20, 6:16-6:30 $40, etc) Persistent late pick-ups (more than 3 in a 3 month period) may result in termination of care. This fee ensures all staff are paid a fair wage for extending their day past closing.

Tuition:

_____Tuition of _____ is paid monthly through Brightwheel by the 5th of each month. Failure to pay tuition will result in termination of services.

_____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.

Parent Signature_____Date_____

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 Date of Child's last Dental 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 contracted, 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 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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Childhood Health History

Child's Name:	Sex: ☐Male ☐Femal	Birthdate:	Today's Date:

Child's Health History

Name of Doctor/Clinic:	City/State:	Phone number:

Were there any significant problems during pregnancy or birth? ☐No ☐Yes, Please explain:

Has your child had surgery or been hospitalized? ☐No ☐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? ☐No ☐Yes, Reason:

Name of medication(s), dosage and when taken:

Has your child had any of the following?

			Age of child or date of incident ▼
Asthma	☐No	☐Yes, describe:	
Other breathing problems	☐No	☐Yes, describe:	
Seizures or other neurological problems	☐No	☐Yes, describe:	
Heart or other cardiovascular problems	☐No	☐Yes, describe:	
Bladder or urinary tract problems	☐No	☐Yes, describe:	
Bowel or other GI problems	☐No	☐Yes, describe:	
Bone or joint problems	☐No	☐Yes, describe:	
Eczema or skin problems	☐No	☐Yes, describe:	
Frequent ear infections or tubes	☐No	☐Yes, describe:	
Other ear, nose or throat problems	☐No	☐Yes, describe:	
Tuberculosis exposure	☐No	☐Yes, describe:	
Chicken Pox or vaccination for such	☐No	☐Yes, describe:	
Diabetes or other endocrine problems	☐No	☐Yes, describe:	
Injury or abuse	☐No	☐Yes, describe:	
Car sickness	☐No	☐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:	☐Cultural	☐Religious	☐Personal	☐Medical/describe:
	☐Cultural	☐Religious	☐Personal	☐Medical/describe:
	☐Cultural	☐Religious	☐Personal	☐Medical/describe:
	☐Cultural	☐Religious	☐Personal	☐Medical/describe:

Does your child have any problems with chewing or swallowing?	☐No	☐Yes, Please describe:

Check the box if you have concerns about your child's:	☐Eating habits	☐Height	☐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***

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? ☐Yes ☐No

List each allergy or food separately	***Briefly describe child's reaction and/or check symptoms***	***Potential Severe Reaction****	***Doctor/Date of Diagnosis***
	☐Hives ☐Wheezing ☐Runny nose ☐Shortness of breath	☐Yes ☐No	
	☐Hives ☐Wheezing ☐Runny nose ☐Shortness of breath	☐Yes ☐No	
	☐Hives ☐Wheezing ☐Runny nose ☐Shortness of breath	☐Yes ☐No	
	☐Hives ☐Wheezing ☐Runny nose ☐Shortness of breath	☐Yes ☐No	
	☐Hives ☐Wheezing ☐Runny nose ☐Shortness of breath	☐Yes ☐No	
	☐Hives ☐Wheezing ☐Runny nose ☐Shortness of breath	☐Yes ☐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?	☐Very good	☐Somewhat good	☐Fair	☐Somewhat bad	☐Very bad

Has your child ever had an injury to the teeth or gums?	☐	☐Yes, please explain:
Has your child complained about pain in the teeth or gums?	☐No	☐ Yes
Is there fluoride in the water at your home, or is your child taking a prescribed fluoride supplement?	☐No	☐ Yes

Parental Concerns

Do you have any concerns about your child's vision?	☐ No	☐ Yes, Please describe:
Do you have any concerns about your child's hearing?	☐ No	☐ Yes, Please describe:
Do you have any concerns about your child's speech?	☐ No	☐ Yes, Please describe:
Do you have any concerns about your child's behavior?	☐ No	☐ Yes, Please describe:
Do you have any concerns about your child's development?	☐ No	☐ Yes, Please describe:
Do you have any other concerns about your child?	☐ No	☐ Yes, Please describe:

Additional information regarding concerns:

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

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.

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*

Certificate of Immunization Status (CIS)

Reviewed by: Date:
Signed COE on File? □ Yes □ No

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

Child's Last Name:	First Name:	Middle Initial:	Birthdate (MM/DD/YYYY):

I give permission to my child's school/child care to add immunization information into the Immunization Information System to help the school maintain my child's record.	Conditional Status Only: I acknowledge that my child is entering school/child care in conditional status. For my child to remain in school, I must provide required documentation of immunization by established deadlines. See back for guidance on conditional status.
X _____ **Parent/Guardian Signature** **Date**	X _____ **Parent/Guardian Signature Required if Starting in Conditional Status** **Date**

▲Required for School ● Required Child Care/Preschool	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY
Required Vaccines for School or Child Care Entry						
●▲ DTaP (Diphtheria, Tetanus, Pertussis)						
▲ Tdap (Tetanus, Diphtheria, Pertussis) (grade 7+)						
●▲ DT or Td (Tetanus, Diphtheria)						
●▲ Hepatitis B						
● Hib (*Haemophilus influenzae type b*)						
●▲ IPV (Polio) (any combination of IPV/OPV)						
●▲ 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)						
COVID-19						
Flu (Influenza)						
Hepatitis A						
HPV (Human Papillomavirus)						
MCV/MPSV (Meningococcal Disease types A, C, W, Y)						
MenB (Meningococcal Disease type B)						
Rotavirus						

Documentation of Disease Immunity (Health care provider use only)

If the child named in this CIS has a history of varicella (chickenpox) disease or can show immunity by blood test (titer), it must be verified by a health care provider.

I certify that the child named on this CIS has:
□ A verified history of varicella (chickenpox) disease.
□ Laboratory evidence of immunity (titer) to disease(s) marked below.

□ Diphtheria	□ Hepatitis A	□ Hepatitis B
□ Hib	□ Measles	□ Mumps
□ Rubella	□ Tetanus	□ Varicella

□Polio (all 3 serotypes must show immunity)

►

Licensed Health Care Provider Signature Date

►

Printed Name

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

Health Care Provider or School Official Name: _____ Signature: _____ Date:_____
If verified by school or child care staff the medical immunization records must be attached to this document.

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

To print with the immunization information filled in:
Ask if your health care provider's office enters immunizations into the WA Immunization Information System (Washington's statewide registry). 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 and birthdate, and sign your name where indicated on page one.
2. 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. 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 health care 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. If your child can show positive immunity by blood test (titer), have your health care provider check the boxes for the appropriate disease in the Documentation of Disease Immunity section, and sign and date the form. You must provide lab reports with this CIS.
5. Provide proof of medically verified records, following the guidelines below.

Acceptable Medical Records
All vaccination records must be medically verified. Examples include:

- A Certificate of Immunization Status (CIS) form printed with the vaccination dates from the Washington State Immunization Information System (IIS), MyIR, or another state's IIS.
- A completed hardcopy CIS with a health care provider validation signature.
- A completed hardcopy CIS with attached vaccination records printed from a health care provider's electronic health record with a health care provider signature or stamp. The school administrator, nurse, or designee must verify the dates on the CIS have been accurately transcribed and provide a signature on the form.

Conditional Status
Children can enter and stay in school or child care in conditional status if they are catching up on required vaccines for school or child care entry. (Vaccine series doses are spread out among minimum intervals, so some children may have to wait a period of time before finishing their vaccinations. This means they may enter school while waiting for their next required vaccine dose). To enter school or child care in conditional status, a child must have all the vaccine doses they are eligible to receive before starting school or child care.

Students in conditional status may remain in school while waiting for the minimum valid date of the next vaccine dose plus another 30 days time to turn in documentation of vaccination. If a student is catching up on multiple vaccines, conditional status continues in a similar manner until all of the required vaccines are complete.

If the 30-day conditional period expires and documentation has not been given to the school or child care, then the student must be excluded from further attendance, per RCW 28A.210.120. Valid documentation includes evidence of immunity to the disease in question, medical records showing vaccination, or a completed certificate of exemption (COE) form.

Reference guide for vaccine trade names in alphabetical order For updated list, visit https://www.cdc.gov/vaccines/terms/usvaccines.html

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 (PV5)
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		

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Sunscreen Authorization Form

Child Care Facility Name:Trinity Lutheran Child Development Center

Parent/Guardian permission is required for all sunscreen applications. 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 10-30 minutes before going outside, especially during the summer months 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.

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: No-Ad 50 SPF or Equate 50 SPF	
Active Ingredient(s): Titanium Dioxide 3.1%, Zinc Oxide 4.0%	
Authorization Form Filled Out on:	Authorization Expires: (6 months from start date)
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:	