Child Care Registration Form

Date child entered care	Date child left care

Child's name (Last, First, Middle)	Name used (Nickname)	Birthdate
Street address	City	Zip code

Child's parent/guardian name	Circle the best number to contact you at when your child is in our care		
	cell phone #	home phone #	alternate phone #
Street address	City		Zip code

Child's parent/guardian name	Circle the best number to contact you at when your child is in our care		
	cell phone #	home phone #	alternate phone #

I give my permission for any of the following individuals to be contacted and my child may be released to any of them.

Parent/Guardian signature: _____ *Date:* _____

In an emergency, if you are not able to contact me, contact the following:

Name (first and last)	cell phone #	home phone #	alternative phone #

These individuals also have permission to pick up my child:

Name (first and last)	cell phone #	home phone #	alternative phone #

Child's health information

Child's medical care provider or parent's/guardian's preferred medical facility for treatment Name: Phone: Street Address:	Child's last physical exam, if available
Child's dental care provider or parent's/guardian's preferred dental facility for treatment Name: Phone: Street Address:	Child's last dental exam, if available

Known health conditions (An individual care plan from child's health care provider is required for any food allergies or special dietary requirement due to a health condition.)

Who does not have permission to pick up your child? If applicable (A copy of supporting court document must be on file)	
Name	Reason

Child's health information		
Date of child's last physical exam:	Child's health care provider	Telephone number ( ) -
Street address	City	Zip code
Special health problems? Yes or no? If yes, specify.	Allergies, including drug reactions Yes or no? If yes, specify.	
Regular medications? Yes or no? If yes, specify.	Other important information Yes or no? If yes, specify.	
Child's dentist's name		Telephone number ( ) -
Street address	City	Zip code

Child's medical insurance coverage	
Insurance company name	Member/policy number
Policy holder name	Employer name
Insurance company name	Member/policy number
Policy holder name	Employer name

Consent to medical care and treatment of minor children

I give permission that my child,_____, may be given first aid/emergency treatment by a the child care licensee and/or qualified staff at:

Name of Licensee The University Childcare,

Address of Licensee

25511 137th Ave SE Kent WA 98042.

Parent/guardian signature	Date	Parent/guardian signature	Date

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 aid car attendant when deemed necessary or advisable by the physician or aid car attendant to safeguard my child's health. I waive my right of informed consent to such treatment.

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

I certify under penalty of perjury under the laws of the State of Washington that this information is true and correct.

Parent/guardian signature	Date	Parent/guardian signature	Date

CHILD CARE AGREEMENT

First	Middle	Last
Child's name:		
First	MIddle	Last
Parent or Guardian name:		

Days and times my child will receive care:

Check days of care	☐ Sunday	☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday	☐ Saturday
Arrival time							
Departure time							

FEE: $_____per: ☐ Hour ☐ Day ☐ Week ☐ Month

Date payment due:

Source of payment:
☐ Parent
☐ Other (specify):

Overtime rate: $ per:

Late fee: $ per:

I agree to promptly notify the child care provider of any changes of the above information. I understand that I am fully responsible for the terms of this agreement as stipulated.

I have read, understand and agree to comply with the policy and procedures and information for parents given to me by:

THE UNIVERSITY CHILDCARE
Name of Licensee

Parent or guardian signature	Date	Parent or guardian signature	Date

I agree to provide child care services according to the above plan. I agree to promptly notify the parents or guardians of any changes to above information.

Licensee signature Date

Street Address	City	State	Zip code
25511 137th Ave SE	Kent	WA	98042

Comments

Washington State Department of CHILDREN, YOUTH & FAMILIES

Child Care Parent/Guardian Permission

Child's Name (First Middle Last)	Licensee's Name

Transportation and off-site activity

I give my permission for the licensee or the licensee's staff to take my child:

	Yes	No
To and/or from school:		
By a personal vehicle	☐	☐
By riding with my child on public transportation	☐	☐
By walking with my child.....	☐	☐
On field trips (a written notice about the field trip will be given at least 24 hours before the field trip is taken): By a personal vehicle	☐	☐
By riding with my child on public transportation	☐	☐
By walking with my child.....	☐	☐
On occasional errands:		
By a personal vehicle	☐	☐
By riding with my child on public transportation	☐	☐
By walking with my child.....	☐	☐
Other (specify here: _____):		
By a personal vehicle	☐	☐
By riding with my child on public transportation	☐	☐
By walking with my child.....	☐	☐

Water activities including swimming pools and other bodies of water

I give my permission for the licensee or the licensee's staff to:

	Yes	No
Take my child swimming or play in a swimming pool or other body of water	☐	☐

Bathing

I give my permission for the licensee or the licensee's staff to:

	Yes	No
Give my child a bath or shower if my child needs to be cleaned after having an accident such as diarrhea or vomiting.....	☐	☐
Give my child a bath or shower if my child is enrolled in overnight child care	☐	☐

Consent to medical care and treatment of minor children

I give permission that my child, _____ may be given first aid/emergency treatment by the child care licensee and or qualified staff at:

Name of Licensee: _____

Address of Licensee: **25511 137th Ave SE Kent WA 98042**

Parent/guardian signature	Date	Parent/guardian signature	Date

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 aid car attendant when deemed necessary or advisable by the physician or aid care attendant to safeguard my child's health. I waive my right of informed consent to such treatment.

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

I certify under penalty of perjury under the laws of the State of Washington that this information is true and correct.

Parent/guardian signature	Date	Parent/guardian signature	Date

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		

The University Childcare
Photo Release Form

I,_____ (Parent) agree to the following

Child(ren)'s name: _____

☐ I will allow my child's photo to be taken and used for promotional purposes on the center website and/or social media.

☐ I will allow my child's photo to be taken and used for display **in the center only.**

☐ **I WILL NOT allow my child's photo to be taken.**

I understand that these photos and/or videos may be used for promotional materials, social media, and/or other marketing purposes related to The University Childcare. This includes, but is not limited to, the following:

- Posting photos and/or videos of my child on The University Childcare's website and social media pages.
- Displaying photos and/or videos of my child in brochures and other promotional materials.
- Using photos and/or videos of my child in advertising campaigns or other marketing initiatives.
- **Capture my child's image on surveillance video used at this child care facility**

I also understand that my child(ren) name may be used in connection with these photos and/or videos.

I acknowledge that I will not receive any compensation for the use of my child's photos and/or videos by The University Childcare.

By signing below, I confirm that I have read and understood this form, and I give my consent for The University Childcare to take photographs and/or videos of my child(ren)'s, and to use these photos and/or videos for promotional and marketing purposes, except for social media unless indicated

Parent/Guardian Name **Print**: _____

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

THE UNIVERSITY CHILDCARE
HANDBOOK ACKNOWLEDGEMENT FORM

I, _____ (print name), have received and read the Parent Handbook and by signing I agree to adhere to all the policies stated within.

Parent/Guardian Name **Print**	Parent/Guardian Signature	Date

The University Childcare		
Program Name	Licensee Signature	Date

25511 137th AVE SE Kent, WA 98042

Program Address

Please sign and return to program

SCAN FOR HANDBOOK