# Annual Enrollment Application and Contract (For Infants)

Child's Name: _____ Date of Birth: _____ Phone Number: _____
Address: _____ City: _____ State: _____ Zip Code: _____

| Session | (F)ull or (P)art Time | Arrival Time | Departure Time |
|---|---|---|---|
| Monday | _____ | _____ | _____ |
| Tuesday | _____ | _____ | _____ |
| Wednesday | _____ | _____ | _____ |
| Thursday | _____ | _____ | _____ |
| Friday | _____ | _____ | _____ |

**Rate** $_____/ Month (max. time allowed is 10 hours/day)
Daily Rate: _____

Date when your child is 16 months: _____
Toddler Monthly Rate: _____
Toddler Daily Rate: _____

**Parent/Guardian Information (persons responsible for tuition):**

Father's Name: _____ Driver's License # or SS#: _____
Employer: _____ Employer's Address: _____
Occupation: _____ _____

Mother's Name: _____ Driver's License # or SS#: _____
Employer: _____ Employer's Address: _____
Occupation: _____ _____

If applicable, Child Care Assistance Case Worker Name and Phone Number: _____

**Enrollment Item Check List:**

_____ Annual Contract Deposit Fee (non-refundable)
_____ Annual Field Trip Fee (non-refundable)
_____ Emergency Data Form
_____ Parent Permission Form
_____ Intake Questionnaire
_____ Parent Volunteer Form
_____ Vaccination Consent Form
_____ Give the following to the child's Dr to complete and/or sign and date:
Physician Directive For Alternative Infant Sleep Position — Date received: _____
Health Care Summary – return within 30 days of enrollment — Date received: _____
Child Care Immunization Record Form – return on or before child's start date — Date received: _____
Medication Form – return on or before child's start date — Date received: _____

_____ Optional: Infant Less Than 6 months of age Regularly Rolling Over
_____ Optional: Parental Consent for Swaddling an Infant
_____ Parent Decline Letter – For Food Benefits
_____ Parent's Instructions on Diet

**Acknowledgment:**

I will not hold Choo Choo Montessori liable for damages or losses to any clothing or articles brought from home. I also understand that children should not bring any jewelry, money, gum, or non-educational toys to the school.

I have read, understand, and agree to abide by all information in the parent policy book. I also understand that from time to time new policies may be implemented as needed and as determined by management and other official governing bodies requiring revisions to current center procedures. Prior notification of policy changes can be expected.

Choo Choo Montessori reserves the right to request that a child be withdrawn if in the opinion of the school, the child does not adjust or benefit from the program or we cannot get along with the parents in a respectable manner. A month's written notice is essential for withdrawing or else you will be billed for that entire period. One day of attendance is considered part of that month. In the event that the account is in default, it will be sent to the collection agency. I (we), the parent/guardian(s), agree to PAY ALL AMOUNTS PAST DUE PLUS THE COSTS OF COLLECTION INCLUDING REASONABLE ATTORNEY FEES.

I hereby understand and agree to the above terms:

_____ _____ _____
Signature of parent/guardian Date Email Address

_____ _____
Signature of Director Date

For Office Use Only:
**Enrollment Date:** _____ **Orientation Date:** _____ **School Email Address for school notifications:** _____
**Sibling Discount (Y or N) Parent Referral:** _____

Choo Choo Montessori, LLC. 2617 Duluth Street. Maplewood, MN 55109. Phone: 651-490-7734. Fax: 651-486-7704. Email: ChooChooMontessori@gmail.com
Last Date of Revision: November 2014

## Emergency Data Card:

All the information asked for on this form is required by the state of MN and must be on file prior to your child's enrollment start date. It is your responsibility to inform us when information on this form should be changed.

| Child's Name: | Nick Name: | Date of Birth: | Gender: M \| F |
|---|---|---|---|

### Parent/Guardian Information

| | |
|---|---|
| **Mother's Name:** | Mother's Home Phone:<br>Address: |
| Work Phone: | |
| Cell Phone: | |
| **Father's Name:** | (If different than Mother's)<br>Father's Home Phone:<br>Address: |
| Work Phone: | |
| Cell Phone: | |

### 2 Emergency Contacts – These 2 adult persons are other than the parents listed above and are authorized to pick up my child in an emergency.

| | |
|---|---|
| **Contact 1 Name:** | Home Phone:<br>Address: |
| Day Time Phone: | |
| Relation to child: | |
| **Contact 2 Name:** | Home Phone:<br>Address: |
| Day Time Phone: | |
| Relation to child: | |

### 2 Alternate Persons Permitted to Pick Up my Child From the Center – These 2 adult persons are other than the emergency contacts listed above and are authorized to pick up my child:

| | |
|---|---|
| **Alternate 1 Name:** | Home Phone:<br>Address: |
| Day Time Phone: | |
| Relation to Child: | |
| **Alternate 2 Name:** | Home Phone:<br>Address: |
| Day Time Phone: | |
| Relation to Child: | |

**(Optional) Other Names and their Phone Numbers of other persons permitted to take my child from the center:**

**(Optional) Persons NOT permitted to take my child from the center:**

### Emergency Medical Information – Note: If your child does not visit a dentist yet, please provide your dentist contact information.

| | | | |
|---|---|---|---|
| **Dentist:** | | | Dentist Address: |
| Dentist Office Phone: | | | |
| **Medical Insurance Company:** | | | **Medical Card ID or assistance number:** |
| **Physician:** | | | Physician Address: |
| Physician Office Phone: | | | |
| **Child's Last DPT:** | **Child's Weight:** | **Child's Allergies:** | |
| **Other significant medical information, including medications:** | | | |

## Emergency Medical Care Permission

In case of an emergency, I authorize Choo Choo Montessori to make whatever emergency (e.g. first aid, disaster evacuation) measures are judged necessary for the care and protection of my child while under the supervision of the Center in the event that I cannot be reached or am late in arriving on the scene.

In case of a medical emergency, I understand that my child will be transported to an appropriate medical facility by the local emergency medical response unit for treatment if the local emergency resource (Police, Rescue Squad), deems it necessary. The child will be transported at the expense of (self or insurance): _____.

Optional: If you would the child to be transported to a hospital other than **St. John's Hospital**, please specify hospital name: _____.

I understand that in some medical situations, the staff will need to contact the local emergency resource before the parent, child's physician, and/or other adult acting on the parent's behalf.

Signature of parent/guardian: _____ Date: _____

# Parent Permission Form (For Infants and Toddlers)

Please provide your initials next to the items that you are giving permission for and then sign and date the bottom of the form.

**Walking Field Trips**
_____ I give permission to the center to take my child on supervised walking excursions.

**Photographs**
_____ I give permission to the center to take photographs of my child and to use them for publicity if they so desire. This also includes use of photographs on the center's website.

**Use of Lotion during Winter Months:**
_____ I allow the staff at Choo Choo Montessori to put unscented lotion on my child's hands after handwashing as needed during the Winter months.

**Use of Sunscreen, Pre-moistened Wipes and Insect Repellants**
_____ I give permission to the center's staff to apply following checked items to my child as needed during outdoor activities:

____ Sun screen lotion (waterproof, SPF 50, and PABA Free)
____ Pre-moistened anti-bacterial wipes
____ Insect repellant with DEET for children ages 2 months and older

*The school will provide the supply of these above checked items.*

**Use of Diapering Products**
_____ I give my permission to the staff at this center to use the following checked diapering items when needed on my child when changing a diaper:

____ Wipes
____ Diaper Rash Cream
____ Diaper Rash Ointment
____ Other, please specify:
_____

*Remember to provide the above checked diapering products on your child's first day and to replenish the supply as needed.*

**Use of Fever Reducing Medicine**
_____ I give my permission to the staff at this center to administer fever reducing medicine to my child as needed until I'm able to pick up my child.

*Please fill out the Medication Form to indicate the type of medicine. Then have the child's physician return the form to us after filling-in the dosage and signing it.*

*Remember to provide the medication on your child's first day and to replenish it as needed.*

**Use of a Cot Instead of a Crib (for infants ages 12 -15 months)**
_____ I give my permission to the staff to allow my child to nap on a cot with a blanket in the infant room.

Signature of parent/guardian: _____ Date: _____

# Intake Questionnaire (For Infants)

Please answer the following questions to help us get to know your child better.

Please list all the child's siblings (Name and Age):

| | |
|---|---|
| 1 | 3 |
| 2 | 4 |

Is the child yours from birth or adoption? __ birth __ adoption

With whom does the child live with? __mother __father or __other, name/relationship to child:_____

How many hours of sleep does your child get: at night? _____ during the day? _____. Please describe any special ways to help your child to nap during the day: _____.

What is your child's favorite color?

What is your child's favorite activity to do with one or more persons? _____ to do by himself/herself? _____

Things you are concerned with about your child: _____

How does your child get along with other children and adults? _____

_____

Briefly describe your child's dietary or medical needs:_____

_____

Other things we should know about your child: _____

_____

Previous Child Care: No ____ or Yes _____; if so, where and how long? _____

Why did you choose our center for your child care needs? _____

_____

Briefly describe your family's race, religion, home language, culture, and family structure. This information will be used to personalize lessons and circle time: _____

_____

_____

_____

Special needs: No ____ or Yes _____; if so, please also provide the Individualized Family Service Plan (IFSP) at the time of enrollment.

Briefly describe how does your child communicates (Sign Language, Body Language, Other Foreign Language, Express Feelings, etc)?

_____

_____

_____

_____

Briefly describe your child's eating habits:

_____

_____

_____

Briefly describe your child's self comforting methods and what would work best for the teacher to comfort your child, if needed:

_____

_____

_____

Where did you hear about Choo Choo Montessori?_____

# Parent Volunteer Form

The school year is underway and the Choo Choo Parent Group is looking for help! Please take a moment to review the opportunities below and let us know if you would be interested in helping in ANY capacity. The Parent Group is organized by parents of students enrolled at the school. We meet monthly and are still working to finalize our meeting schedule for this year. Please indicate your interest in leading or helping with one or more of the following activities:

**Monthly Volunteer Opportunities**

- ☐ **Parent group coordinator** - Plan and attend monthly parent group meetings and coordinate the above-listed parent group activities.
- ☐ **Classroom material coordinator** - Help prepare art crafts (trace or cut).
- ☐ **Bulletin board coordinator** - Maintain the parent group bulletin board and remind parents of the monthly sign up to donate flowers or food items to the classroom. Parents are also encouraged to bring in books about certain topics.
- ☐ **Early childhood topic coordinator** - During parent group meetings we often have time to learn about early childhood development and the Montessori approach. This position would help coordinate what topics will be covered and planning the presenters.
- ☐ **Staff birthday coordinator** - Communicate with other Choo Choo families when staff birthdays are approaching and suggest staff favorites so parents that are interested can treat staff on their special day. This position can be done from home.

**Quarterly Volunteer Opportunities**

- ☐ **Communications coordinator** - Create flyers to inform families of upcoming parent group activities. This can be done from home.
- ☐ **Social events coordinator** - Plan monthly outings for Choo Choo families to get together outside of school. For example, trips to the park, walk a thons, group play dates, parent coffee time, etc. This position will work in coordination with the parent group and can be done from home.
- ☐ **Staff appreciation coordinator** - Plan the annual staff appreciation event in May. Coordinate volunteers to help.
- ☐ **Fundraising coordinator** - Plan and organize fundraising events in coordination with owners. For example, the Monkey House event, Montessori Services, Book Fair, or a silent auction.

**Extra information**

Please be specific on how much time or what kind of involvement you would be willing to put forth. For example maybe you would like to help organize staff appreciation but are not comfortable with leading or collecting money.

**What days of the week work best for you to attend a parent group meeting?**

Meetings usually take place in the late afternoon/early evening.

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

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I, _____, am interested in receiving information about the above checked volunteer activities

parent's name

during the time period of _____.

month/year – month/year

Signature: _____ Date: _____ School Email Address: _____

# Vaccination Record Sharing Consent Form

Minnesota law allows for the sharing of immunization information between schools, health care providers, and public health agencies. One way we do this is by each of these entities contributing the immunization records we have to one computer system that is available only to us, called the Minnesota Immunization Information Connection (MIIC). This system is operated by the Minnesota Department of Health and contains only basic name and address information plus vaccines names and dates. It is used solely to help prevent disease by improving immunization services in our community. The information can only be shared with those entities authorized by Minnesota law (Minn. Stat. §144.3351) to receive it.

If you choose to not have your child's immunization information in this system, it does not affect any school services. It may, however, mean more work for you, your child's clinic, and/or school staff to determine your child's immunization status as part of Minnesota's School Immunization Law.

I authorize Choo Choo Montessori to release my child's immunization record to the public health immunization registry. I understand this information can only be used to improve the quality and timeliness of immunization services and to help schools enforce the School Immunization Law. This includes any immunization information the school currently has on my child plus any it may obtain during the time that my child is enrolled and attends the school.

- ☐ I do authorize
- ☐ I do not authorize

Child's Name: _____ Date of Birth: ___/___/____

Parent's signature: _____ Date: ___/___/____

Minnesota Department of **Human Services**

# OPTIONAL FORM FOR PARENT STATEMENT
# INFANT LESS THAN SIX MONTHS OF AGE REGULARLY ROLLING OVER

An infant who independently rolls onto its stomach after being placed to sleep on its back may be allowed to remain sleeping on its stomach if the infant is at least six months of age or the license holder has a signed statement from the parent indicating that the infant ***regularly rolls over*** at home. Minnesota Statutes, section 245A.1435

**Name of Infant:** _____

**Date of Birth of infant (MM/DD/YYYY):** _____

By completing this form, I (the parent) attest that my infant ***independently and regularly rolls over onto its stomach*** after being placed to sleep on its back. I (the parent) acknowledge that while in the care of the licensed program, my infant will be placed on its back to sleep and that when my infant independently rolls over onto its stomach while sleeping, the license holder may allow my infant to remain sleeping on its stomach.

**Name of Parent:** _____ **Name of Parent:** _____

**Signature of Parent:** _____ **Signature of Parent:** _____

**Date Signed:** _____ **Date Signed:** _____

***Please Note: The use of this form for the parent's signed statement is optional.***

March 11, 2014 V.1

Minnesota Department of **Human Services**

# Parental Consent for Swaddling an Infant

Placing a swaddled infant down to sleep in a licensed setting is ***not*** recommended for an infant of any age* and is prohibited for any infant who has begun to roll over independently.

However, with written consent of a parent or guardian, a license holder may place the infant who has NOT YET BEGUN to ROLL OVER ON ITS OWN down to sleep in a crib, on their back, in a one-piece sleeper equipped with an attached system that fastens securely ONLY across the upper torso, with no constriction of the hips or legs, to create a swaddle.

***Any other type of swaddle, including with a blanket, is prohibited.***

Prior to any use of swaddling for sleep by a licensed provider, the license holder must obtain informed written consent for the use of swaddling from the parent or guardian of the infant. The parent or guardian must demonstrate to the provider how to safely place baby in the swaddle so it is not too tight or too loose.

I _____, the parent/guardian of _____ DOB_____
(parent) (infant)

give written consent to _____
(provider)

***To place my infant to sleep in a crib, on their back, in a one-piece sleeper equipped with an attached system ("wings") that fastens securely ONLY across the upper torso to create a swaddle.***

**_____I verify that my infant has NOT yet begun to roll over.**
**_____I verify that the provider will only use the one-piece sleeper to swaddle my infant**
**_____I verify that the provider has a one-piece sleeper with attached "wings" OR**
**_____I verify that I have provided the one-piece sleeper with attached "wings"**
**_____I verify that I have demonstrated to the provider how to place baby in the swaddle.**
**_____I verify that I will immediately notify the provider when my infant has begun to roll over.**

Signature of Parent _____ Date _____

Signature of Provider_____ Date _____

***At the time that the parent or provider observes that this infant has begun to roll over, this parental consent is no longer valid.***

**Baby has begun to roll over. Swaddling has been discontinued.**

**Date: _____ Provider Initials: _____Parent Initials: _____**

*Caring for our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, Third Edition 2012

# Parent Decline Letter

The school provides the following food and beverage items:

- Iron-fortified Costco formula (infants)
- commercial infant food in jars
- commercial infant cereal

Please check all boxes needed to describe your infant's current feeding situation: Sign, date, and return to the center.

I understand that program benefits are being offered to my infant, I am choosing to decline program benefits for my infant at this time, but I understand that I can change my mind at any time and receive program benefits.

I decline to receive food program benefits for my infant at this time because (check all that may apply):

- ☐ I choose to provide breast milk for my infant.
- ☐ I choose to provide breast milk and _____ formula* for my infant.
- ☐ I choose to provide _____ formula* for my infant.
- ☐ I choose to supply my own infant cereal and/or foods for my infant in lieu of the infant cereal and/or foods provided by this center.

* I understand that I will Submit a special Diet Statement if I am supplying a low-iron infant formula or other specialized formula for my infant.

Infant's Name: _____ Parent's Name: _____

Date: _____ Parent's Signature: _____

In the operation of child feeding programs, no child will be discriminated against because of race, color, national origin, sex, age, or disability.

# Parent's Instruction on Diet

Infant's Name: _____ Birth Date: _____ Today's Date: _____

Please outline your infant's daily diet. Include beverage preferences and schedule for providing food and beverages to your child. If needed, specify when to provide vitamin or iron supplements.

Beverage Preferences (check all that apply):
__ My child is breast fed
__ My child is bottle fed
Type of Bottle _____ Type of Nipple _____
Formula Brand _____ Milk Type _____
__ My child drinks for a sippy cup
__ My child drinks from a regular cup

__ My child uses a spoon

Please list the **amounts** of food and beverages you would like fed to your child each day. If the times listed differ than your current feeding times, also specify an ideal ½ hr **time slot** for each feeding. Note the number of feedings depends on the infant's age and schedule you choose for your infant.

| *Time* | *Milk (Breast Milk, Formula or Cow's Milk)* | *Cereal* | *Fruit* | *Vegetable* | *Meat* |
|---|---|---|---|---|---|
| Breakfast (7-9am) | | | | | |
| Morning Snack (10:30-11:00a) | | | | | |
| Lunch (12-1p) | | | | | |
| Afternoon Snack (3-4p) | | | | | |
| Evening Snack (5-5:45p) | | | | | |

For infants 12 months and older: Tuition includes breakfast, lunch and snack. See breakfast, lunch, and snack menus for food that is provided.

Also include any special techniques you may recommend for feeding your infant: _____

_____

_____

_____

_____

Minnesota Department of **Human Services**

# Physician Directive for Alternative Infant Sleep Position

The American Academy of Pediatrics (AAP)*, National Institute of Child Health and Human Development (NICHD) and the Minnesota Sudden Infant Death (SID) Center at Children's Hospitals and Clinics of Minnesota recommend back sleeping for babies to reduce the risk of sudden unexpected infant deaths (SUID) due to sudden infant death syndrome, suffocation, and other sleep related causes. The 2011 AAP recommendation further states that an alternative sleep position be considered only for the rare exception of infants for whom the risk of death when sleeping on the back is greater than the risk of SUID when sleeping on the stomach. **Babies sleep safest on their backs.**

Minnesota law requires that licensed providers place infants to sleep in a crib, directly on a firm mattress. The provider must place the infant on his/her back for sleep unless the provider has a signed directive from a physician for an alternate sleep position for the infant. Car seats, swings, couches, the floor on a blanket, etc. are **not** acceptable as an alternative sleep position.

**This form is the approved format to direct an alternative sleep position and must remain on file at the licensed location.**

In addition, Minnesota law requires licensed providers to use a fitted crib sheet that fits tightly on the mattress and overlaps the underside of the mattress so it cannot be dislodged by pulling on the corner of the sheet with reasonable effort. Nothing may be placed in crib with the infant except the infant's pacifier. These requirements apply to license holders serving infants up to one year of age. Licensed providers may only use cribs that meet requirements specified in statute and must inspect cribs monthly to assure they are safe.

**I understand that back sleeping is recommended and is safest for babies. I am directing an alternative position for this infant for the reason(s) stated below. By signing this form I am acknowledging that I am directing only an alternative sleep position and that the infant must always be placed in an approved crib to sleep.**

| NAME OF CHILD | DATE OF BIRTH |
|---|---|
| | |

_____ Place this infant on his/her STOMACH for sleep periods (***not recommended); OR***

_____ Place this infant on his/her SIDE for sleep periods (***not recommended)***

Medical Reason(s) for alternate sleep position:_____
(attach information if necessary)

Expected duration of need for alternate sleep position:_____

When infant will be re-evaluated re: need for alternative sleep position:_____

| PRINTED NAME AND SIGNATURE OF PHYSICIAN | DATE |
|---|---|
| | |

**(Licensed providers must place an infant in a crib to sleep. Car seats, swings, couches, the floor on a blanket, etc. are <u>not</u> acceptable as an alternative sleep position.)**

| SIGNATURE OF PARENT | DATE |
|---|---|
| | |
| SIGNATURE OF PROVIDER | DATE |
| | |

*Moon RY, American Academy of Pediatrics, Task Force on Sudden Infant Death Syndrome. Technical Report - SIDS and other sleep related infant deaths: expansion of recommendations for a safe infant sleeping environment. *Pediatrics 2011. 128(5) available at www.pediatrics.org/cgi/content/full/128/5/e*

# ALTERNATIVE INFANT SLEEP POSITION
# PARENT AND PROVIDER INFORMATION

One of the easiest ways to lower a baby's risk of Sudden Unexpected Infant Death (SUID) due to sudden infant death syndrome (SIDS), suffocation, and other sleep related causes is to put the baby on the back to sleep for naps and at night. Health care providers used to think that babies should sleep on their stomachs, but research now shows that babies are less likely to die of SUID when they sleep on their backs. Since the recommendation to place a baby on their back for sleep began, the SIDS rate in the United States has dropped by more than 50 percent. Placing babies on their back to sleep is the best way to reduce the risk of SUID.

**The following are recommended for Safe Sleep for Your Baby:**

1. Always place a baby on his or her back to sleep, for naps and at night. The back sleep position is the safest position for all babies and every sleep time counts.
2. A baby should be put to sleep in a safety-approved crib on a firm mattress covered by a fitted sheet appropriate to the mattress size.
3. Keep soft objects, toys, loose bedding, pillows, blankets, quilts, sheepskins and crib bumpers out of the baby's sleep area. The only item that should be placed in the crib with the baby is a pacifier. **Please note: In licensed programs, the only item allowed in a crib with an infant is a pacifier.**

• As the parent providing this physician signed form I am acknowledging that I have read the above information regarding the AAP and NICHD recommendations for sleeping babies safely, Minnesota's requirements for licensed providers, and recommendations from **Safe Sleep for Your Baby.**

The Safe Sleep for Your Baby Brochure may be viewed at:
https://www.nichd.nih.gov/publications/pubs/Documents/STS_SafeSleepForYourBaby_General_2013.pdf

• As the parent providing this physician signed form I am acknowledging that I am aware that placing a baby on her/his back for sleep has been recommended by health experts to be the safest way to place a baby for sleep.

• As the parent providing this physician signed form I am acknowledging that I am aware that since the recommendation to place babies on their back for sleep began, the SIDS rate in the United States has dropped by more than 50 percent.

• As the parent providing this physician signed form I am acknowledging that I am aware that placing a baby on the stomach or side, places the baby at greater risk for dying from Sudden Unexpected Infant Death (SUID).

• As the parent providing this physician signed form I am acknowledging that I am aware that Minnesota Statute, Section 245A.1435, requires licensed providers to position an infant on the back for sleep unless the provider has a signed directive from a physician for an alternate sleep position.