PRECIOUS MEMORIES EARLY CHILDHOOD LEARNING CENTER
PRESCHOOL ENROLLMENT APPLICATION

- ☐ Eligibility and Enrollment From
- ☐ Family Household Information
- ☐ Child History
- ☐ Social Relationship
- ☐ Health Assessment
- ☐ Emergency Medical Form
- ☐ Emergency Contact List
- ☐ Pick-Up Authorization Form
- ☐ Thirty-Two-Months-Authorization
- ☐ Disciplinary Measures
- ☐ Toilet Trained Agreement Policy for Preschoolers
- ☐ Parent Work Schedule
- ☐ Transportation Form (English & Spanish)
- ☐ Permission Slip for Walks & Field Trip
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- ☐ Parent Agreement Form
- ☐ Food Allergy Alert Form
- ☐ Lunch Form in (English & Spanish)
- ☐ *Birth Certificate or Passport*
- ☐ *Health Insurance*
- ☐ *Proof of Income: W-2, Recent Pay Stub* & Residency

You are required to complete this form completely

PRECIOUS MEMORIES EARLY CHILDHOOD LEARNING CENTER
PRESCHOOL ENROLLMENT APPLICATION

Registration Application Form

Application must be completed to be considered

Enrollment Date: _____ **Gender**: _____

Child's Name: _____
Last **First** **Middle Initial**

Child's Date of Birth: _____

Parent Email Address: _____

Address: _____
Number **Street**

_____
City/Town **State** **Zip Code**

Home Telephone Number: _____

Alternate Number: _____

Place of Birth: _____

Child lives with: _____Both Parents _____Mother _____Father
_____Grandparent(s) _____Foster parent _____Other

Ethnicity: _____American Indian or Native Alaskan ____White ____Black
_____ Hispanic _____Asian or Pacific Islander

PRECIOUS MEMORIES EARLY CHILDHOOD LEARNING CENTER
PRESCHOOL ENROLLMENT APPLICATION

Family Household Information

Mother/ Guardian Name: _____ D.O.B_____

Place of Employment: _____

Employer's Address: _____

Business Telephone: _____ **Alternate Number**: _____

Working Hours: **A.M._____** **P.M._____**

Father's Name: _____

Place of Employment: _____

Employer's Address: _____

Business Telephone: _____ Alternate Number: _____

Working Hours: A.M. _____ P.M. _____

Head of household: _____

Family Size_____ What Language is spoken at home _____

Are you attending school? _____ Training program_____if yes,

Where_____ Hours_____

Childcare hours needed: A.M. _____ to P.M. _____

Note: Childcare hours are provided according to your work schedule.

PRECIOUS MEMORIES EARLY CHILDHOOD LEARNING CENTER
PRESCHOOL ENROLLMENT APPLICATION

Gross Family Income Before Taxes

	Type	Amount	Weekly/ Monthly
Father	_____	_____	_____
Mother	_____	_____	_____
Guardian	_____	_____	_____
Other/Specify	_____	_____	_____

Type: Wages, Social Security, Welfare, Unemployment, Child Support, Pension, VA Benefits, etc. (Verification must be presented)

Have you received TANF in the last (6) six months? Yes _____ No____

Social Service Office: _____

TANF Case Number: _____

Is your child covered by health insurance? Yes ___ No ___

If yes, please provide the name of insurance information including policy number:

_____

Parent/Guardian Signature: _____Date_____

Director/ Head Teacher Signature:_____Date_____

PRECIOUS MEMORIES EARLY CHILDHOOD LEARNING CENTER
PRESCHOOL ENROLLMENT APPLICATION

Emergency Contact list, other than the parents

Name: _____

Address: _____

Home Phone: _____

Work Phone: _____

Alternate Phone: _____

Name: _____

Address: _____

Home Phone: _____

Work Phone: _____

Alternate Phone: _____

Name: _____

Address: _____

Home Phone: _____

Work Phone: _____

Alternate Phone: _____

I give permission for the names listed above to pick up my child in case of emergency.

Parent Signature: _____Date_____

Director/Head Teacher Signature: _____Date_____

PRECIOUS MEMORIES EARLY CHILDHOOD LEARNING CENTER
PRESCHOOL ENROLLMENT APPLICATION

Pick-Up Authorization Form

Other than parents, who are over the age of 18 that are responsible for pick up and drop off child.

Child's Name: _____
Parent(s) Name: _____
Phone Number: _____

The following person(s) have my permission to drop off and pick up child to and from Precious Memories Early Childhood Program.

1. Name: _____

   Home Phone: _____

   Work Phone: _____

   Address: _____

   Relationship with Child: _____

2. Name: _____

   Home Phone: _____

   Work Phone: _____

   Address: _____

   Relationship with Child: _____

3. Name: _____

   Home Phone: _____

   Work Phone: _____

   Address: _____

   Relationship with Child: _____

Parent Signature: _____Date: _____

Director/Head Teacher Signature: _____Date: _____

PRECIOUS MEMORIES EARLY CHILDHOOD LEARNING CENTER
PRESCHOOL ENROLLMENT APPLICATION

Permission Slip For Walks & Field Trip

Child's Name: _____

I give Precious Memories permission to take my child on walks and field trips, around or outside of Precious Memories ground.

I further give permission for my child to use all the play equipment and participate in all activities of the center.

I understand the nature of the walking trip is for children to participate in program activities such as science, nature, weather, and muscle development.

I understand the purpose of the procedures governing the trip. I/we hereby grant permission for my child to participate. I also understand that unanticipated situations can arise on any trip, childcare-sponsored or otherwise, that are not reasonably within the control of the supervising staff. In such an instance, I agree that Precious Memories Early Childhood Learning and supervising staff will not be held legally responsible in the event of an accident or injury.

Parent/Guardian Signature **Date**

Director Signature/Head Teacher **Date**

PRECIOUS MEMORIES EARLY CHILDHOOD LEARNING CENTER
PRESCHOOL ENROLLMENT APPLICATION

Parent(s) Work Schedule

Child's Name:_____

Please provide us with your work schedule, for us to contact you if needed. If there are any changes to your work schedule, please inform the Head Teachers or Director of Precious Memories Learning Center.

Work Schedule:

Mother: Monday – Friday Time: _____

Father: Monday – Friday Time: _____

Parent/ Guardian Signature **Date**

Director/ Head Teacher Signature Date

Toilet Trained Agreement Policy for Preschool ages (3-5)

Precious Memories policy expects most children are developmentally ready and fully toilet trained. We understand that the children do have accidents, and in this case, the teachers will encourage the child to change him/herself and will assist the child if he/she is unable to do so. The children cannot be left in soiled clothing; the teacher will inform you if your child requires extra clothing on site. The program requires extra pairs of clothing to be on site for your child, in case of any accident. Parents must cooperate with the program policy, for us to make their child as comfortable as possible in this situation.

If this agreement is not upheld by the parent(s) you will be called to pick up the child from the program.

Parent/Guardian Signature **Date**

Director/Head Teacher Signature **Date**

Payment Contract

I _____, agree to the payments schedule of Precious Memories. I also understand that if my payments are in arrears, my child will not be admitted in the program. All unpaid balances will be sent to the collection agency for further actions.

_____

Parent/ Guardian Signature **Date**

_____

Director/ Head Teacher Signature **Date**

PRECIOUS MEMORIES EARLY CHILDHOOD LEARNING CENTER
PRESCHOOL ENROLLMENT APPLICATION

Policy Agreement

I _____, have read and understand the policy
(Name of Parent(s) or Guardian)

of Precious Memories Early Childhood Learning Center.

_____

Parent/Guardian signature **Date**

_____

Director /Head Teacher Signature **Date**

PRECIOUS MEMORIES EARLY CHILDHOOD LEARNING CENTER
PRESCHOOL ENROLLMENT APPLICATION

Child's History

Child's Name: _____

Others living in the child's home (siblings, grandparents, etc.)

Name	**Age**	**Relationship**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pet: _____Yes _____No

Language child speak:

Language used primarily in the home: _____
Language(s) child speak: _____

Health:

What communicable diseases has your child had? _____
What is the birth order of your child? _____
Note other serious illnesses or hospitalization: _____

Note any physical disabilities: _____
Note any allergies, including food allergies: _____
Note any medication given regularly: _____

Toilet Habits:

_____Is your child toilet trained? _____Have frequent accidents?

Sleeping Habits

Bedtime _____ Rising Time_____ Nap Time _____

Social Relationship:

Does your child spend time with his/her parents: Yes_____ No _____?

PRECIOUS MEMORIES EARLY CHILDHOOD LEARNING CENTER
PRESCHOOL ENROLLMENT APPLICATION

If the child lives with one parent, how often do they see their other parent _____?

Has your child had frequent play experiences with peers? ____Yes ____No?

Generally, how were these experiences? _____

How is your child's temperament? _____Friendly ____Aggressive _____Other (describe) _____

How does your child adjust to a new situation? _____

How does your child relate to strangers? _____

Has your child been in childcare before? _____

What makes your child angry or upset? _____

How does your child show his/her feelings?
_____

Who disciplines your child? _____ How?
_____

What is the best way to handle your Child?
_____

What are your child's fears?
_____

Do you have any concerns about your child's development? _____Yes _____No

If you have any concerns regarding your child, please note below:
_____
_____
_____

_____
Parent Signature/Guardian **Date**

_____
Director/Head Teacher Signature **Date**

PLANS FOR CHILD NOT PICKED UP AT CLOSING

PARENTS ARE ALLOWED **½ HOUR AFTER** CLOSING TO PICK UP THEIR CHILD. TWO STAFF, **EIGTEEN OR OLDER**, WILL BE ON THE LICENSED PREMISES WITH THE CHILD AT ALL TIMES. A STAFF PERSON WILL TRY TO CONTACT THE PARENT AT WORK/HOME. IF WE ARE UNABLE TO REACH THE PARENT, THE EMERGENCY NUMBERS PROVIVDED BY THE PARENTS WILL BE USED.

THE PEOPLE ON THE LIST WILL BE CONTACTED. **ADULTS WHO ARE ARHTOURIZED TO PICK UP CHILDREN MUST BE 18 YEARS OLD OR OLDER.** IF WE ARE UNABLE TO CONTACT ALL OF THE ABOVE PEOPLE WITHIN FORTY-FIVE MINUTES, THE NEXT ALTERNATIVE IS TO CONTACT THE POLICE AND THE DEPARTMENT OF CHILDREN.

_____

Parent Signature **Date**

_____

Director/ Head Teacher Signature **Date**

PRECIOUS MEMORIES EARLY CHILDHOOD LEARNING CENTER
PRESCHOOL ENROLLMENT APPLICATION

Emergency Medical Policy and Permission

Child's Name _____

Physician _____

Telephone _____

I hereby grant permission for Precious Memories staff to take whatever steps may be necessary to obtain emergency medical care, if warranted, at Bridgeport or St. Vincent Hospital, or the nearest emergency medical facility when there is an emergency. These steps may include, but are not limited to the following:

1. Trained staff will administer emergency first aid as needed.

2. Attempt to contact a parent or guardian.

3. Accompany child to the Bridgeport Hospital located five minutes away from our program.

4. Attempt to contact parents through any of the people listed on the emergency Information form you completed for us.

5. If we cannot contact you or your child's physician, we will do anything or all Following: (a) call a ambulance, (b) call another physician, (c) have the child taken to an emergency hospital in the company of a staff member.

6. In the likely event that surgery or another medical treatment is necessary, and Parents cannot be contracted; your permission signed below will be accepted.

7. Any expense incurred under item # 5 above will be borne by the child's family If not, Precious Memories related.

8. The childcare center will not be responsible for anything that may happen because of false information given at the time of the enrollment.

9. Child's physician or clinic needs to be notified in case of an emergency if parent or guardian cannot be reached. Please note below this information.

_____ _____

Physician's/Clinic's Complete Name **Date**

_____

Physician's/Clinic's Complete Address

Parent/Guardian Signature: _____

PRECIOUS MEMORIES EARLY CHILDHOOD LEARNING CENTER
PRESCHOOL ENROLLMENT APPLICATION

Nutrition Assessment

Child's Name: _____

Do you, as parent/guardian, have food or nutrition concerns for your child?
Yeas_____No_____. If yes, please explain:

_____
_____

Does your child require a special diet? Yes_____ No_____. f yes, please explain:

_____
_____

Does your child have food allergies or intolerances? Yes_____No_____. If yes, please explain:

_____
_____

Does your child take daily medication or vitamin supplements? Yes_____No_____.
If yes, please explain:

_____
_____

Describe your child's typical eating behaviors. (check all that apply)
_____appropriate mealtime behavior
_____eats well
_____eats poorly
_____sit calmly and pay attention to eating
_____socialize with others during mealtime
_____uses appropriate eating skills

Is your child's growth pattern (height and weight) normal? ___Yes, _____No. if no, please explain:_____

Staff Observations **Date_____**

Eating Behavior:
_____eats well ___socializes with others during mealtime
_____eats poorly ___uses appropriate eating skills
_____sits calmly
Height _____ Weight _____ Date_____
Height_____ Weight _____ Date_____

_____

Parent Signature **Date:**

PRECIOUS MEMORIES EARLY CHILDHOOD LEARNING CENTER
PRESCHOOL ENROLLMENT APPLICATION

Family Needs Assessment Form

Child's Name: _____ Family Name: _____
Phone: _____ Parent' Work Phone: _____
Ethnicity:_____ Primary Language: _____, (other than English) assistance required? Yes____ No___.

Do you have a need for:
Medical help? Y____ N____
Dental help? Y____ N____
Mental Health Help? Y_____N____

Is your child insured by Husky or private insurance? Y_____N___.

Does your child have a disability? Y_____ N____.

Is your child receiving any service(s)? Y____ N___.
If yes, please specify what type of service_____.

Do you have a need for food assistance, such as WIC? Y_____N_____

Family Literacy: What's the highest grade completed by each family

member. Name Grade Completed

_____
_____
_____
_____
_____

Do you have a need or interest in more information for any of the following?

Basic Literacy (improving English, Reading, and Writing skills)? __Y ____N
ESL-English as a Second Language (for speakers of other languages) ___Y _N
Job Training (to up-grade skills or learn new work skills) ___Y ___N
Adult Education (to learn practical, craft, work-related, or literacy skills __Y ___N.

Parent Signature: _____ Date: _____

Permission for Photograph/Video Taping & Posting Children Activities on Program Website & Social Media.

Precious Memories Early Childhood Learning Center has video cameras in all classrooms that tape the daily activities of the children. On occasions, the teachers will take pictures of the children participating in the program's educational activities within their classrooms or on field trips. Some of these pictures are posted in the classrooms and on the program website for viewing.

In addition, the program will now use social media platforms, including Facebook program, to share children's educational activities, classroom projects, and program promotions. These posts are used to highlight learning experiences and keep families informed and connected.

I understand the children's classrooms are being videotaped daily and sometimes pictures are taken of the children doing their educational activities within the classroom or on field trips. I'm aware that these pictures may be posted in the classrooms, on the program website, or on the program's official social media pages (such as Facebook).

Parent Signature: _____ Date: _____

Social Media Consent
I give Precious Memories permission to post my child's picture engaging in educational activities in the classroom, on field trips**,** or on the program's social media pages (including Facebook).

☐ **Permission given**

☐ **Permission not given**

Parent Signature: _____ Date: _____

ACCEPTED AND PROHIBITED DISCIPLINARY MEASURES

All program staff will be instructed in the use of the following disciplinary measures to encourage the development of self-esteem in the children:

1. The preparation and supervision of the children which prevent conflicts before they arise.
2. The use of words and mediation to settle disputes and conflict among children.
3. The use of a positive approach to discipline.
4. Provide an environment which encourages and supports positive interactions.
5. Consistent and developmentally appropriate limits and expectations for children which reflect their understanding and safety.
6. Use of redirection techniques to encourage appropriate behavior.
7. If all fails, the separation of a child from the situation or from other children to an alternate place or activity within the classroom until the child is ready to discuss the situation and to rejoin the other children.
8. Staff will continuously supervise children during disciplinary actions.
9. The emotional support needed to assist a child in achieving his/her self-control.

Prohibited disciplines include:

Staff shall not be abusive, neglectful, or use corporal, humiliating or frightening punishment under any circumstances. In addition, **teaching staff must never use physical punishment including, but not limited to, spanking, slapping, pinching, shaking, or striking a child, jerking; squeezing; kicking; biting; excessive tickling; and pulling of arms; hair; or ears; requiring a child to remain inactive for a long period of time**. Staff must not engage in psychological abuse such as shaming; name calling; ridiculing; humiliation; sarcasm; cursing at, making treats, or frightening a child, ostracism, or withholding affection. Coercion is not allowed such as rough handling, (shaking, pulling, grasping, of any body parts); forcing a child to sit down, lie down, or stay down, except when restraint is necessary to protect the child or other from harm; physically forcing a child to perform an action (such as eating or cleaning up). Never use treats or derogatory remarks and neither withhold nor threaten to withhold food as a form of discipline.

I have read, discussed, and understood the disciplinary policy of Precious Memories.

Parent Signature:_____ Date_____

Director/Head Teacher Signature: _____Date_____

Thirty-Two to Thirty-Six Months Authorization Agreement Form for Preschool Enrollment

We are a preschool who accept children ages three and four-years-old. Under Public Act 19-121 section 14, we are deemed to accept children aged thirty-two to thirty-six months with written authorization between parents and our childcare director. It is important to note that your child will be considered three years of age, and all regulations including ratio and group size for three-year-old would apply.

Upon receiving a signed authorization your child will be placed with his/her classmates with adequate supervision. Our curriculum will also be adjusted to fit your child's learning needs.

I have read and understand the agreement for placing my child under three years old into a preschool classroom with children who are three and four years old.

Parent Signature_____Date_____

Director /Head Teacher Signature _____Date_____

If you should have any concerns, please do not hesitate to bring it to our attention.

Parking Lot Policy

Precious Memories' parking lot is **private property** and is **not licensed, approved, or monitored by the Connecticut Office of Early Childhood (OEC)** as part of the program's licensed childcare space.

In accordance with OEC licensing regulations, **only OEC-approved indoor and outdoor spaces may be used for routine childcare activities**. The parking lot is **not considered a licensed play or learning area** and may **not** be used for unsupervised child activities.

The parking lot may only be used by children **under the following limited conditions**:

- The area is **temporarily closed to all vehicle traffic**
- Access is **restricted and controlled by staff**
- The activity is **program-approved, planned, and directly supervised**
- Use is limited to special events or structured activities (e.g., family events, supervised bike days)

At all other times, including arrival and dismissal:

- The parking lot is **not a play area**
- Children are **not permitted** to run, play, or ride bikes
- Parents/guardians are responsible for **direct supervision** of their child
- Children must remain **with and under the control of their parent/guardian**

In accordance with OEC safety expectations:

- Children are under **parent supervision** until they are signed in and officially accepted into care
- Children return to **parent supervision** immediately upon sign-out
- Precious Memories is not responsible for incidents occurring in the parking lot **outside of supervised, program-approved activities**

For safety, all parents, guardians, and authorized pick-up persons must:

- Follow posted traffic and safety guidelines
- Never allow children to walk, run, or play freely in the parking lot
- Hold younger children's hands and ensure children remain close at all times

Failure to follow this policy may result in corrective action to ensure compliance with safety standards and OEC expectations.

Parking Lot Usage Policy Acknowledgment

I acknowledge that I have read and understand the Precious Memories Parking Lot Usage Policy. I understand that the parking lot is private property and is **not licensed or approved by the Connecticut Office of Early Childhood (OEC)** for routine childcare use. I understand that I am responsible for supervising my child during arrival, departure, and any time the parking lot is open for vehicle use. I agree to follow all safety and supervision requirements outlined in this policy.

Parent/Guardian Name: _____

Signature: _____

Date: _____

Parent Agreement Form

Days and Hours of Operation
The center is open Monday through Friday from 7 a.m. to 5:00 p.m., year-round. We follow the (name of town) school schedule for holidays and vacations. Tuition is due weekly regardless of any absence, sick days, and including programs' closing.

Admission
Our program serves children 24 weeks to 4 years old. A $38.00 non-refundable registration fee, along with one week's tuition, is due upon registration. Tuitions payments are to be made weekly, and due the Friday before the week of care. If your weekly fee is not made. Your child may not return until payment is made in full. **a late fee of $15.00 will be charged for every five minutes.** We understand circumstances can hinder parents from picking up their child on schedule from time to time, however if the parent knows that he/she will be late and made prior arrangement(s) with us a **$10.00** fee will be added for every five minutes (until the child) is picked up. If a parent continuously picks up his/her child late, the child will be dismissed from the program. Each child entering the center must have an updated physical form, signed and dated by his/her pediatrician, including current immunization documentation. Children who are not school age, must have their physicals updated yearly. Children who are of school age are required to have a physical upon entering Kindergarten and then as required by the school district for which that child attends and acceptable to the local education authority.

Payment Policies:

It is standard practice to charge for national holidays that fall during our normal hours of operation. The director will complete a tuition contract for the days and hours requested before your child begins school. The director and the person that will be responsible for the payment must sign the contract. Payments must be made to the school's director each week, unless other arrangements have been made with the director. Full payment, as stated in the contract, is due even if your child is absent. Missed days cannot be made up. **Tuition is due on the first day of your child's school week. If payment is still not received by Tuesday morning, your child will not be able to return to school the following day unless accompanied with a payment**. If the tuition is past due, your child will not be allowed in the program. Once again, all legal and collection fees incurred in the collection of tuition are the responsibility of the parent.

RETURNED CHECK FEES

$28.00 penalty for returned checks

LATE FEE

A late charge of **$15.00** will be charged for each **(5) minutes**, if a child is not picked up at the normal closing hour. If parent continues to be late, the child will be dismissed for the program.

Payment Options:
Precious Memories accepts Credit Card, Cash, Check, Money order, or Cashier's check for payments.

Parent Agreement Form

Agreements with Parents

- Please call and let a staff member know if your child is going to be absent for any reason.
- An adult must accompany your child to and from his/her classroom and sign them in and out each day, adult must be 18 or older.
- Please leave at least 2 spare outfits in your child's cubby labeled with their name on it. Parents must supply diapers, and label bottles for baby formulas, etc.
- Toys are not to be brought from home except on specified days.
- Parents are not allowed to supply bedding for cribs. The program will provide snug bedding for cribs.
- Any changes in address, phone number, employment, etc. must be given to the director in writing.

In case of inclement weather, a text notification will be sent to all parents and parents can also contact the 24-hour answering service or listen to radio station **99.9 or WICC 600 a.m., and WEBE 108 F.M. and view the Television Channel 8 and 12 for closings or delays.** In case an emergency occurs, the center will contact you or the authorized adult listed on your authorization form to pick up your child if necessary.

Program Emergency Phone Line:
In the event our phone line goes down due to inclement weather or loss of Wi-Fi. All parents can have access to our program through our designated phone for emergencies. The Program's emergency phone numbers are: **PM1- 203-873-7798, PM3-203-873-1892, & PM4-203-673-9579.**

Damage to Property:
Children are expected to treat all property within our facility with respect, including but not limited to toys and furniture. The parent(s) or guardian will be responsible for the willful destruction of any property at our facility.

Custody Battles:
We at Precious Memories Childcare center consider the children's safety as our number one priority. We ask all parents(s) to please notify the director if there are any custody hearings or changes in pickup authorization for your child. However, if the center does not have any legal documents on file stating the parent(s) is not authorized to pick his or her child, the center cannot hold the child, because that parent(s) still has legal custody.

Parent Agreement Form

Administrative Oversight
We strive to ensure that the day-to-day operations of our program are aligned with the current Connecticut Statues and Regulations for Child Care Centers and Group Child Care Homes, the Program Policies, Plans and Procedures, Program Philosophy and best practice. Our program works hard to ensure that all children, families, and program staff have a positive experience. Most concerns can be resolved by:
1. Discussing the issue with the classroom teacher.
2. Discussing the issue with the program director or director's designee.

Name of Designated Director: _____
- Telephone #:_____ Email: _____

Name of Alternate Person in Charge: _____
- Telephone #: _____ Email: _____

1. At times if a concern or issue that is raised may need more attention, a meeting between the parties can be set at a mutually agreed upon time with the parties which can include the parents/ guardians, classroom teacher/ program staff, the head teacher/ alternate person in charge, and the director. We appreciate other perspectives and are committed to continuous quality improvements that will make the experience within our program a positive and nurturing one for all.

1. If during this meeting should there be an impasse and a resolution that cannot be reached, the matter will be brought to the attention of the administrative leadership team which includes the executive director.

2. If the problem is not resolved, you may contact the Connecticut Office of Early Childhood Licensing Division.
3.

In case of an emergency, the program will notify the Licensing Division as soon as the emergency is under control.

✓ By phone to the Complaint Desk at (800) 282-6063 or (860)500-4450 or
✓ By filing online at www.ctoec.org/contact-us/file-a-complaint

Abuse & Neglect
In case of abuse/neglect or life-threatening situations the program will call 911 or the Department of Children and Families (DCF) at (800) 842-2288 and the OEC Division of Licensing.

Parent Agreement Form

All inspection reports and corrective action plans are available for your review:
✓ At your childcare program
✓ Online at www.211childcare.org, or
✓ By FOI request from the OEC Licensing Division:

Meals and Snacks
"Snack" means a light meal containing two (2) meal components/ food items
"Meal" means the food served and eaten in one sitting containing three (3) meal components/food items for breakfast and five (5) meal components/food items for lunch.

The center will provide breakfast, lunch and snacks including milk and 100% fruit juice. Menus are posted on the family information board and on ProCare for parents to view.
Parents with children who have special arrangements regarding their child's lunch is responsible for supplying their child's lunch box. Be sure to label their lunch and provide an ice pack for items that may be perishable.

Provisional Enrollment
The first 30 days will be regarded as a trial period, in which either party may terminate the contract without notice. After the first 30 days of enrollment, please see the withdrawal policy in the handbook.

Family Involvement/Access to Program and Facility
Our center has an open-door policy. Parents and guardians are encouraged to visit their children whenever possible. The center also plans periodic educational and fun field trips. Volunteers are more than welcome.

Withdrawal and/or Disenrollment of Children
Parents or guardians must provide the center with 2 weeks' written notice prior to withdrawing their child from the center. All tuition owed must be paid in full. Likewise, if possible, the program will provide the same courtesy if care for a child must be disenrolled for any reason. The program will work with all children and families to avoid a child's disenrollment.

Medication Policies
*See full medication policy for details

Confidentiality: All information received or given will be kept confidential. No information will be shared without parent consent.

Health Policy:
Precious Memories requests that parents DO NOT send his/her child to the center if he/she has a new cold. Unless the cold has been diagnosed as an allergy; if the child vomits, has a temperature, diarrhea, gross nasal discharge, red throat, and reddened eyes in the morning or the previous night, PLEASE NOTIFY THE TEACHER IF YOUR CHILD WILL NOT BE IN SCHOOL. Should a child become ill during the day, the child will be made comfortable in an area of the center until he or she is picked up. If the child has a temperature of 100 or above the parent will be notified to pick up his/her child from the center. Once the child is sent home, due to continuous vomiting, high temperature, diarrhea, etc., your child needs to stay home for 24 hours until all symptoms of illness are gone.

Parent Agreement Form

Contagious Disease:
Please notify the TEACHERS IMMEDIATELY if your child has a contagious disease. We need to notify our parents that their child has been exposed. Children will not be allowed in the center without a doctor's note stating it is safe for the child to attend the center. Depending on the disease, we will discuss the appropriate action to follow.

Immunization:

Precious Memories request your child's immunization records on or before the first day of school. A child will not be accepted in the program without the proper immunization documents. These records should be signed and dated by your child's physician. The physical must have occurred within the last year. An annual seasonal influenza and Hepatitis A vaccines is required for children 6months to 4years. All children born on or after January 1, 2009, ages 12 to 23months are required to have 1 dose of Hepatitis A vaccine; two doses are required for 24 months and older. If a child has not received the flu vaccine, he/she will be excluded from our program for the duration of influenza season, until they receive at least one dose of the influenza vaccine. Children with religious exemption shall be permitted to attend the program except in the case of a vaccine-preventable disease outbreak within our program. All susceptible students will be excluded from our program based on public health officials' determination that the school is a primary site for disease exposure, transmission and spread into the community. An annual physical or an immunization exempt form is required for your child to attend the program. A copy of the physical or exempt form is confidentially kept in your child's file. If you need a medical home, health insurance, or dental service, or any other additional services please notify the program director for assistance.

Allergy Free Environment
To better protect the children due to food allergies, Precious Memoires is a nuts environment.

ID Requirement:
Other than the parent(s), an ID is required for pickup of any children within our program. Staff will cross reference signatures

Parent Signature: _____ Date_____

Director/ Head Teacher Signature: _____ Date: _____

State of Connecticut Department of Education
Early Childhood Health Assessment Record
(For children ages birth–5)

To Parent or Guardian: In order to provide the best experience, early childhood providers must understand your child's health needs. This form requests information from you (Part 1) which will be helpful to the health care provider when he or she completes the health evaluation (Part 2) and oral health assessment (Part 3). State law requires complete primary immunizations and a health assessment by a physician, an advanced practice registered nurse, a physician assistant, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to entering an early childhood program in Connecticut.

Please print

Child's Name (Last, First, Middle)	Birth Date (mm/dd/yyyy)	❑Male ❑Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
Early Childhood Program (Name and Phone Number)	Race/Ethnicity ❑American Indian/Alaska Native ❑Native Hawaiian/Pacific Islander ❑Asian ❑White ❑Black or African American ❑Other ❑Hispanic/Latino of any race	
Primary Health Care Provider: Name of Dentist:		
Health Insurance Company/Number* or Medicaid/Number*		
Does your child have health insurance? Y N Does your child have dental insurance? Y N Does your child have HUSKY insurance? Y N	If your child does not have health insurance, call **1-877-CT-HUSKY**	

* If applicable

Part 1 — To be completed by parent/guardian.
Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Frequent ear infections	Y	N	Asthma treatment	Y	N
Allergies to food, bee stings, insects	Y	N	Any speech issues	Y	N	Seizure	Y	N
Allergies to medication	Y	N	Any problems with teeth	Y	N	Diabetes	Y	N
Any other allergies	Y	N	Has your child had a dental examination in the last 6 months?	Y	N	Any heart problems	Y	N
Any daily/ongoing medications	Y	N				Emergency room visits	Y	N
Any problems with vision	Y	N	Very high or low activity level	Y	N	Any major illness or injury	Y	N
Uses contacts or glasses	Y	N	Weight concerns	Y	N	Any operations/surgeries	Y	N
Any hearing concerns	Y	N	Problems breathing or coughing	Y	N	Lead concerns/poisoning	Y	N
Developmental — Any concern about your child's:						Sleeping concerns	Y	N
1. Physical development	Y	N	5. Ability to communicate needs	Y	N	High blood pressure	Y	N
2. Movement from one place to another	Y	N	6. Interaction with others	Y	N	Eating concerns	Y	N
			7. Behavior	Y	N	Toileting concerns	Y	N
3. Social development	Y	N	8. Ability to understand	Y	N	Birth to 3 services	Y	N
4. Emotional development	Y	N	9. Ability to use their hands	Y	N	Preschool Special Education	Y	N

Explain all "yes" answers or provide any additional information :

Have you talked with your child's primary health care provider about any of the above concerns? Y N

Please list any **medications** your child will need to take during program hours:

*All medications taken in child care programs require a separate **Medication Authorization Form** signed by an authorized prescriber and parent/guardian.*

I give my consent for my child's health care provider and early childhood provider or health/nurse consultant/coordinator to discuss the information on this form for confidential use in meeting my child's health and educational needs in the early childhood program.

Signature of Parent/Guardian Date

C.G.S. Section 10-16q, 10-206, 19a-79(a), 19a-87b(c); P.H. Code Section 19a-79-5a(a)(2), 19a-87b-10b(2); Public Act No. 18-168

Part 2 — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation, physical examination and immunization record.

Child's Name_____ Birth Date_____ (mm/dd/yyyy) Date of Exam _____ (mm/dd/yyyy)

❑I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider.

***HT**____in/cm_____% ***Weight**____lbs._____oz /_____% **BMI**____/_____% ***HC**____in/cm_____% (Birth–24 months) ***Blood Pressure**____/ ____ (Annually at 3–5 years)

Screenings *According to Bright Futures Periodicity Schedule

***Vision Screening**
❑ EPSDT Subjective Screen Completed (Birth to 3 yrs.)
❑ EPSDT Annually at 3 yrs. (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑Unable to assess
❑Referral made to: _____

***Hearing Screening**
❑ EPSDT Subjective Screen Completed (Birth to 4 yrs.)
❑ EPSDT Annually at 4 yrs. (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
	❑ Pass	❑Pass
	❑ Fail	❑Fail

❑Unable to assess
❑Referral made to: _____

***Anemia:** at 9 to 12 months and 2 years

***Hgb/Hct:** | *Date

***Lead:** at 9 and 35 months; at 36-72 months, annually if enrolled in a public assistance program, and PA 22-49 and in PA 23-31.

***History of Lead Level ≥ 3.5 ug/dL** ❑No ❑Yes

***TB:** High-risk group? ❑No ❑Yes
Test done: ❑No ❑Yes Date: _____
Results: _____
Treatment: _____

***Dental Concerns** ❑No ❑Yes
❑Referral made to: _____
Has this child received dental care in the last 6 months? ❑No ❑Yes

*Result/Level: *Date

Other:

***Developmental Assessment:** (Birth–5 years) ❑No ❑Yes **Type:**

Results:

*IMMUNIZATIONS ❑Up to Date or ❑Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

Asthma ❑No ❑Yes: ❑Intermittent ❑Mild Persistent ❑Moderate Persistent ❑Severe Persistent ❑Exercise induced
*If yes, please provide a copy of an **Asthma Action Plan***
❑Rescue medication required in child care setting: ❑No ❑Yes

Allergies ❑No ❑Yes: _____
Epi Pen required: ❑No ❑Yes
History/risk of Anaphylaxis: ❑No ❑Yes: ❑Food ❑Insects ❑Latex ❑Medication ❑Unknown source
*If yes, please provide a copy of the **Emergency Allergy Plan***

Diabetes ❑No ❑Yes: ❑Type I ❑Type II **Other Chronic Disease:** _____
Seizures ❑No ❑Yes: Type: _____

❑ This child has the following problems which may adversely affect his or her educational experience:
❑Vision ❑Auditory ❑Speech/Language ❑Physical ❑Emotional/Social ❑Behavior
❑ This child has a developmental delay/disability that may require intervention at the program.
❑ This child has a special health care need which may require intervention at the program, e.g., special diet, long-term/ongoing/daily/emergency medication, history of contagious disease. *Specify:* _____

❑No ❑Yes This child has a medical or emotional illness/disorder that now poses a risk to other children or affects his/her ability to participate safely in the program.
❑No ❑Yes Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.
❑No ❑Yes This child may fully participate in the program.
❑No ❑Yes This child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.)

❑No ❑Yes Is this the child's medical home? ❑ I would like to discuss information in this report with the early childhood provider and/or nurse/health consultant/coordinator.

Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped ***Provider*** Name and Phone Number

Part 3 — Oral Health Assessment/Screening

Health Care Provider must complete and sign the oral health assessment.

To Parent(s) or Guardian(s):

State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

Student Name (Last, First, Middle)	Birth Date	Date of Exam
School	Grade	❑Male ❑Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination	**Visual Screening**	Normal	**Referral Made:**
Completed by: ❑Dentist	Completed by: ❑MD/DO ❑APRN ❑PA ❑Dental Hygienist	❑Yes ❑Abnormal (Describe) _____ _____ _____ _____	❑Yes ❑No

Risk Assessment	**Describe Risk Factors**	
❑Low	❑Dental or orthodontic appliance	❑Carious lesions
❑Moderate	❑Saliva	❑Restorations
❑High	❑Gingival condition	❑Pain
	❑Visible plaque	❑Swelling
	❑Tooth demineralization	❑Trauma
	❑Other_____	❑Other _____

Recommendation(s) by health care provider: _____

_____

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

_____

Signature of Parent/Guardian Date

_____

Signature of health care provider	DMD / DDS / MD / DO / APRN / PA/ RDH	Date Signed	Printed/Stamped ***Provider*** Name and Phone Number

Child's Name:_____ **Birth Date:**_____ REV. 3/2024

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) _____

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP/DT						
IPV/OPV						
MMR						
Measles						
Mumps						
Rubella						
Hib						
Hepatitis A						
Hepatitis B						
Varicella						
PCV* vaccine					*Pneumococcal conjugate vaccine	
Rotavirus						
MCV**					**Meningococcal conjugate vaccine	
Flu						
Other						

Religious Exemption: _____

Religious exemptions must meet the criteria established in Public Act 21-6: https://www.ctoec.org/wp-content/uploads/2021/07/OEC-Vaccination-QA-Final.pdf.

Medical Exemption: _____

Must have signed and completed medical exemption form attached. https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/infectious_diseases/immunization/CT-WIZ/CT-Medical-Exemption-Form-final-09272021fillable3.pdf

Disease history of varicella: _____(date); _____(confirmed by)

Immunization Requirements for Connecticut Day Care, Family Day Care and Group Day Care Homes

Vaccines	Under 2 months of age	By 3 months of age	By 5 months of age	By 7 months of age	By 16 months of age	16–18 months of age	By 19 months of age	2–3 years of age (24-35 mos.)	3–5 years of age (36-59 mos.)
DTP/DTaP/ DT	None	1 dose	2 doses	3 doses	3 doses	3 doses	4 doses	4 doses	4 doses
Polio	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
MMR	None	None	None	None	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]
Hep B	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
HIB	None	1 dose	2 doses	2 or 3 doses depending on vaccine given[3]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]
Varicella	None	None	None	None	None	None	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]
Pneumococcal Conjugate Vaccine (PCV)	None	1 dose	2 doses	3 doses	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday
Hepatitis A	None	None	None	None	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	2 doses given 6 months apart[5]	2 doses given 6 months apart[5]
Influenza	None	None	None	1 or 2 doses	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]

1. Laboratory confirmed immunity also acceptable
2. Physician diagnosis of disease
3. A complete primary series is 2 doses of PRP-OMP (PedvaxHIB) or 3 doses of HbOC (ActHib or Pentacel)
4. As a final booster dose if the child completed the primary series before age 12 months. Children who receive the first dose of Hib on or after 12 months of age and before 15 months of age are required to have 2 doses. Children who received the first dose of Hib vaccine on or after 15 months of age are required to have only one dose
5. Hepatitis A is required for all children born after January 1, 2009
6. Two doses in the same flu season are required for children who have not previously received an influenza vaccination, with a single dose required during subsequent seasons

_____

Initial/Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number