I have received and read the Parent Handbook.

Date____________Signature_____________________________

$100.00 registration fee is due when enrollment forms are submitted

COOKS HILL COMMUNITY CHILDCARE CENTER

2400 Cooks Hill Road.
Centralia, WA 98531
360-807-1760

Child's Name__________________________ Nickname*(if any):*___________________

Address ____

Date of Birth________________________Sex_______Telephone_____________
Ethnic(Optional) American Indian or Alaskan Native___Asian or Pacific Islander__
White___Black___Other___

Email Address: ___________________________

Other Members of the Household

Name	Relationship to Child	Age

Person(s) responsible for child____

Relationship____

By whom will childcare be paid?____
Signatures of legal guardians and others you want to pick up your child.

Print Full Name	Sign Full Name	Initials	Phone

Address_____________________________Wk Phone ___________________________

____

Address_____________________________Wk Phone___________________________

____

Address______________________________ Wk Phone____________________________

Page 2 Registration

FATHER	MOTHER
Name___________________________	Name__________________________
Address_________________________	Address________________________
Home Phone_____________________	Home Phone___________________
Employer_______________________	Employer______________________
Address_________________________	Address________________________
Work Phone______________________	Work Phone____________________
Hours of Employment_____________	Hours of Employment____________

AUTHORIZATION

Person to contact in emergency if we are unable to reach parents:

Name________________________Address________________________Phone_________

Name________________________Address________________________Phone_________

Physician to be called in emergency: Name________________________Phone_________

Please check yes or no:

Yes___ No___ I hereby authorize the Cooks Hill Childcare Center to call my family doctor for my child in case of sudden illness or accident. If unable to reach my doctor, the staff doctor meets with my approval.

Yes ___No ___ My child may be taken on field trips or excursions by bus or private motor vehicle under proper supervision.

Yes ___No ___ My child may have his her picture taken and used for publicity or news purposes.

Yes ___No ___ My child may go to the Chapel (large play space) on a daily basis

Date of Admission ______________ Date of Withdrawal_____________________

Signature of Parent/Guardian____

Signature of Child Care Center Representative__________________________________

Page 3 Registration

PERSONAL INFORMATION ABOUT CHILD

Does your child have any obvious birthmarks?___________If so, where?____________

Has your child been in custody of other than parents?_______If so, who?____________

Has your child had day care, preschool or play group experience?___________________

Does your child play with other children often?__________________________________

Does your child get along well with other children?______________________________

Does your child need occasional help in dressing?_______________Undressing_______

Does your child need help with eating?____

Are there foods/drinks to avoid?____

Are there likes/dislikes we should know about?__________________________________

Does your child need frequent snacks to maintain energy?_________________________

Does your child need occasional help using the restroom?_________________________

Does your child need to be reminded to use the restroom?_________________________

Does your child usually nap during the day?_____________AM__________PM_______

What does the word "discipline" mean to you?__________________________________

What sort of discipline do you find most effective with your child?_________________

Other information you feel we should have about your child.______________________

Page 4 Registration

In the event that I choose to remove my child from childcare at CHCCC, I agree to leave information on how I may be contacted.

I understand that all fees are payable in advance unless otherwise arranged with the Director of CHCCC.

I agree to pay the late charge fee of $1.00 per every minute late after 6PM (unless prior arrangements have been made with the Director or Program Supervisor).

Signature_____________________________________Date_________________________

PLEASE BRING THE FOLLOWING ITEMS FOR YOUR CHILD TO HAVE AVAILABLE WHILE AT OUR CENTER- EVERYTHING LABELED WITH PERMANENT MARKER. PLEASE.

FULL CHANGE OF CLOTHES:

- SHOES
- SOCKS
- LONG PANTS
- SHIRT
- COAT WITH NAME

- 1 BLANKET AND 1 CRIB SHEET *(REQUIRED BY STATE LAW) There is a $5 weekly fee if you do not bring your child a sheet & blanket for laundry services*

PLEASE BRING THE FOLLOWING ITMES ALSO, IF THEY APPLY TO YOUR CHILD:

- DIAPERS (EXTRAS)
- RASH MEDICATION, IF NEEDED
- BOTTLE
- BINKY
- SECURITY ITEM SUCH AS A TOY OR BLANKET
- BABY WIPES

CHCCC HEALTH INFORMATION

Child's Name____Birthdate____________

Mother____Work Phone____________

Father____Work Phone___________

EMERGENCY: If parents cannot be reached, contact:
Name________________________Phone_________________Relationship____________

Name________________________Phone_________________Relationship____________

Physician:
Name__________________

Regular Medications:
____

Phone____

Date of last physical exam____

Date of last dental exam____

Date of last eye exam____

Does this child have any specific health problems, which the staff should be aware of? (Vision or hearing loss, allergies, including drug reactions, convulsions, seizures, etc.?)
Yes ______No_____If yes, please explain.______________________________________

Has your child had any serious illnesses that might affect their participation in day care activities? (Accidents, surgeries or communicable diseases such as measles, mumps, chicken pox, etc.)____

Primary Medical Insurance Coverage____
Dental_________________________________Eye________________________________
Employer____
Group Number_____________________________Membership Number______________

==

CONSENT TO MEDICAL CARE AND TREATMENT OF MINOR CHILDREN

_____________________________, the natural parent/guardian of ___________________ authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health and I cannot be contacted. This includes emergency first aid and CPR by qualified childcare staff.
Signature _________________________Hm Phone____________Work______________
Address____

All About Me
For My Teacher

My name is: ____

My Birthday is: ____

My Parents are: ____

Allergies? ____

I do/do not have a pacifier.

I have________ brothers ________ sisters

Their names are: ________________________________ Age: ____________

________________________________ Age: ____________

________________________________ Age: ____________

I have _________ pets.

Their names are: ____

____

My favorite color is: ____

Something special about me is:____

My favorite thing to do is: ____

My diapers are: ___________________ Diaper rash ointment: ______________________

Things that are stressful for me: ____

Medical Information: ____

What word does your child use for toileting?: _________________________________

Foods I like: ______________________ Foods I dislike: _______________________

I am ___________ handed.

Please list any group contact your child has had with other children:

____

Certificate of Immunization Status (CIS)

DOH 348-013 January 2015

Office Use Only:
Reviewed by: Date:
Signed Cert. of Exemption on file? ❑ Yes ❑ No

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

Child's Last Name: **First Name:** **Middle Initial:** **Birthdate** (mm/dd/yyyy): **Sex:**

Symbols below: ◆ Required for School and Child Care/Preschool
● Required for Child Care/Preschool Only
■ Recommended, but not required

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

Parent/Guardian Signature Required **Date**

I give permission to my child's school to share immunization information with the Immunization Information System to help the school maintain my child's school record.

Parent/Guardian Signature Required **Date**

Vaccine	Dose	Date		
		Month	Day	Year
◆ **Hepatitis B (Hep B)**				
	1			
	2			
	3			
or Hep B - 2 dose alternate schedule for teens				
	1			
	2			
■ **Rotavirus (RV1, RV5)**				
	1			
	2			
	3			
◆ **Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)**				
	1			
	2			
	3			
	4			
	5			
◆ **Tetanus, Diphtheria, Pertussis (Tdap)**				
	1			
■ **Tetanus, Diphtheria (Td)**				
	1			
	2			
● ***Haemophilus influenzae* type b (Hib)**				
	1			
	2			
	3			
	4			
■ **Influenza (flu, most recent)**				

Vaccine	Dose	Date		
		Month	Day	Year
● **Pneumococcal (PCV, PPSV)**				
	1			
	2			
	3			
	4			
	5			
◆ **Polio (IPV, OPV)**				
	1			
	2			
	3			
	4			
◆ **Measles, Mumps, Rubella (MMR)**				
	1			
	2			
◆ **Varicella (chickenpox)**				
	1			
	2			
■ **Hepatitis A (Hep A)**				
	1			
	2			
■ **Human Papillomavirus (HPV) – does not print from the IIS; write dates in by hand**				
	1			
	2			
	3			
■ **Meningococcal (MCV, MPSV)**				
	1			
	2			

If the child named on this CIS had chickenpox disease (and not the vaccine), disease history must be verified.
Mark option 1, 2, OR 3 below (see # 5 on back)

1) ❑ Chickenpox disease verified by printout from the Immunization Information System (IIS)
Must be marked by printout (not by hand) to be valid.

2) ❑ Chickenpox disease verified by healthcare provider (HCP)
If you choose this box, mark 2A **OR** 2B below.
2A) ❑ Signed note from HCP attached **OR**
2B) ❑ HCP sign here and print name below:

Licensed healthcare provider signature (MD, DO, ND, PA, ARNP) **Date**

Printed Name:

3) ❑ Chickenpox disease verified by school staff from the Immunization Information System

If the child can show immunity by blood test (titer) and hasn't had the vaccine, ask your HCP to fill in this box.

Documentation of Disease Immunity

I certify that the child named on this CIS has laboratory evidence of immunity (titer) to the diseases marked.
Signed lab report(s) MUST also be attached.

❑ Diphtheria
❑ Hepatitis A
❑ Hepatitis B
❑ Hib
❑ Measles
❑ Mumps
❑ Polio
❑ Rubella
❑ Tetanus
❑ Varicella
❑ Other: ____________

Licensed healthcare provider signature (MD, DO, ND, PA, ARNP) **Date**

Printed Name:

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

#1 To print with information filled in: First, ask if your healthcare provider's office puts vaccination history into the WA Immunization Information System (Washington's statewide database). If they do, ask them to print the CIS from the IIS and your child's information will fill in automatically. **Be sure** to review all the information, **sign and date the CIS**, and return it to school or child care. If your provider's office does not use the IIS, ask for a copy of your child's vaccine record so you can fill it in by hand using steps #2-7 (below):

#2 To fill in by hand: Print your child's name, birthdate, sex, and your own name in the top box.

#3 Write each vaccine your child received under the correct disease. Write the vaccine type under the "Vaccine" column and the date each dose was received in the "Month," "Day," and "Year" columns (as mm/dd/yyyy). For example, if DTaP was received Jan 12, March 20, June 1, '11, fill in as shown here ▶

EXAMPLE

Vaccine	Dose	Date		
		Month	Day	Year
◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)				
DTaP	**1**	01	12	2011
DTaP	**2**	03	20	2011
DTaP	**3**	06	01	2011

#4 If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guide 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**.

#5 If your child had chickenpox (varicella) disease and not the vaccine, **use only one** of these three options to record this on the CIS:

1) ❑ If your child's CIS is printed directly from the IIS (by your healthcare provider or school), and disease verification is found, box 1 is automatically marked. To be valid, this box must be marked by the IIS printout (not by hand).

2) ❑ If your healthcare provider can verify that your child had chickenpox, mark box 2. Then mark either 2A to attach a signed note from your provider, or 2B if your provider signs and dates in the space provided. Be sure your provider's full name is also printed.

3) ❑ If school staff access the IIS and see verification that your child had chickenpox, they will mark box 3.

#6 Documentation of Disease Immunity: If your child can show immunity by blood test (titer) and has not had the vaccine, have your healthcare provider fill in this box. Ask your provider to mark the disease(s), sign, date, print his or her name in the space provided, and **attach signed lab reports**.

#7 Be sure to **sign and date the CIS**, and return to the school or child care.

Reference Guide

Vaccine Trade Names in alphabetical order (For updated lists, visit https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf)

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB	Hib	FluLaval	Flu	Ipol	IPV	PedvaxHIB	Hib	Twinrix (Twnrx)	Hep A + Hep B
Adacel	Tdap	FluMist	Flu	Infanrix	DTaP	Pentacel (Pntcl)	DTaP + Hib + IPV	Vaqta	Hep A
Afluria	Flu	Fluvirin	Flu	Kinrix (Knrx)	DTaP + IPV	Pneumovax	PPSV or PPV23	Varivax	Varicella
Boostrix	Tdap	Fluzone	Flu	Menactra	MCV or MCV4	Prevnar	PCV or PCV7 or PCV13		
Cervarix	HPV2	Gardasil	HPV4	MenHibrix (Mnhbrx)	Meningococcal C/Y-HIB-PRP	ProQuad (PrQd)	MMR + Varicella		
Daptacel	DTaP	Havrix	Hep A	Menomune	MPSV or MPSV4	Recombivax HB	Hep B		
Engerix-B	Hep B	Hiberix	Hib	Menveo	Meningococcal	Rotarix	Rotavirus (RV1)		
Fluarix	Flu	HibTITER	Hib	Pediarix (Pdrx)	DTaP + Hep B + IPV	RotaTeq	Rotavirus (RV5)		

Vaccine Abbreviations in alphabetical order (For updated lists, visit https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf)

Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus	Hep A (HAV) Hep B (HBV)	Hepatitis A Hepatitis B	MPSV or MPSV4	Meningococcal Polysaccharide Vaccine	Rota (RV1 or RV5)	Rotavirus
DTaP	Diphtheria, Tetanus, acellular Pertussis	Hib	*Haemophilus influenzae* type b	MMR / MMRV	Measles, Mumps, Rubella / with Varicella	Td	Tetanus, Diphtheria
DTP	Diphtheria, Tetanus, Pertussis	HPV	Human Papillomavirus	OPV	Oral Poliovirus Vccine	Tdap	Tetanus, Diphtheria, acellular Pertussis
Flu (IIV or LAIV)	Influenza	IPV	Inactivated Poliovirus Vaccine	PCV or PCV7 or PCV13	Pneumococcal Conjugate Vaccine	TIG	Tetanus immune globulin
HBIG	Hepatitis B Immune Globulin	MCV or MCV4	Meningococcal Conjugate Vaccine	PPSV or PPV23	Pneumococcal Polysaccharide Vaccine	VAR or VZV	Varicella

If you have a disability and need this document in another format, please call 1-800-525-0127 (TDD/TTY call 711).