



UNIVERSITY OF
LOUISVILLE

EARLY LEARNING CAMPUS

FOR STAFF USE ONLY

School Year **2019-20**

Classroom _____

Emergency Contact Information / Pick-up Release Form

Child's Name: _____

Birth Date: _____

Contact Information

	Parent 1/Legal Guardian Gender: M F	Parent 2/Legal Guardian Gender: M F
Name	First: Last:	First: Last:
Home Address City, State Zip		
Work Address City, State Zip		
Preferred E-mail Address		
Home Phone		
Cell Phone		
Work Phone		

The ELC will not accept phone calls or emails as authorization for others to pick up your child. It is your responsibility to give advanced, written permission for any and all possible persons to whom the ELC is allowed to release your child, if you are not available. Please list contacts **IN THE ORDER** that you would like them to be contacted in the event of an emergency. Contacts **MUST PROVIDE A PICTURE ID** in order to pick up your child. By signing this form, you give the ELC permission to share health information about your child with the people listed as emergency contacts.

Name: _____

Telephone Number: _____

Relationship to Child: _____

Can this Person be contacted in case of an emergency? Yes No

Name: _____

Telephone Number: _____

Relationship to Child: _____

Can this Person be contacted in case of an emergency? Yes No

Name: _____

Telephone Number: _____

Relationship to Child: _____

Can this Person be contacted in case of an emergency? Yes No

Signature of Parent or Guardian

Date

FOR STAFF USE ONLY

School Year **2019-20**

Classroom _____

Additional Authorized Pick-ups

Child's Name: _____ **Birth Date:** _____

We must have advanced, WRITTEN permission from you to release your child to another person. Emailed permissions or phone calls cannot be accepted. Please list the names of any and all possible persons to whom the ELC is allowed to release your child, if you are not available. List contacts **IN THE ORDER** that you would like them to be contacted in the event of an emergency. Contacts **MUST PROVIDE A PICTURE ID** in order to pick up your child. *These emergency contacts will not be privy to your child's health information.*

Name: _____ Telephone Number: _____
 Relationship to Child: _____ Can this Person be contacted in case of an emergency? Yes No

Name: _____ Telephone Number: _____
 Relationship to Child: _____ Can this Person be contacted in case of an emergency? Yes No

Name: _____ Telephone Number: _____
 Relationship to Child: _____ Can this Person be contacted in case of an emergency? Yes No

Name: _____ Telephone Number: _____
 Relationship to Child: _____ Can this Person be contacted in case of an emergency? Yes No

Name: _____ Telephone Number: _____
 Relationship to Child: _____ Can this Person be contacted in case of an emergency? Yes No

Name: _____ Telephone Number: _____
 Relationship to Child: _____ Can this Person be contacted in case of an emergency? Yes No

Signature of Parent or Guardian

Date



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Childcare Consent and Wavier

I (We), the Undersigned Parent(s)/Guardian(s) for _____, am the parent and/or legal guardian of the child and have the right and authority to enroll this child in a child care program. In consideration of the childcare services offered by the University of Louisville Early Learning Campus, I hereby release the Early Learning Campus, Scholar House, the University of Louisville, and their agents, employees and directors, from any and all liabilities or damages relating to my child’s participation and enrollment in the University of Louisville Early Learning Campus (hereinafter “ELC”).

I affirm that I have had the opportunity to tour the premises at Scholar House where the ELC intends to operate and that I have had the opportunity to interview the ELC staff. I further agree that my family’s participation in the ELC is completely voluntary and based upon an informed decision.

I understand that my child will be given the opportunity to participate in physical and group activities that will be supervised by the trained staff members of the ELC and the staff will make every effort to ensure my child’s safety. However, I acknowledge that physical and group activities carry an inherent risk of injury and I hereby release the ELC, Scholar House, the University of Louisville, and their agents, employees and directors from any and all liability should my child become injured while participating in ELC activities.

I understand that should my child become injured or ill, the ELC staff will take immediate action to help my child, including, but not limited to, administering basic first aid, administering basic CPR, calling and reporting 911 life-or-limb-threatening emergency, and that by signing this form, I have given my express consent to do so. I also understand that as soon as possible following my child’s accident or illness, an ELC staff member will contact me. I agree to leave an emergency phone number so that the ELC staff may contact me if needed.

I understand that any special medical conditions my child has must be provided in writing, with appropriate instructions should a medical situation arise, and that emergency medications may only be administered with a physician’s note. I understand that the ELC will be providing food and beverage to my child throughout the day. I understand that any special food allergies or requirements my child has must be provided in writing with appropriate instructions. I will provide substitute food or snacks alternatives I wish my child to have.

I further understand that my child may be dropped off at the ELC start time and that he/she is to be picked up no later than the ELC end time. Should the need arise for my child to remain at the ELC any longer than this, I will contact the ELC ahead of time. I further understand that I will be responsible for paying late charges as outlined in the Enrollment Contract (which are subject to change by the staff of ELC at its discretion). I understand that continued late pick-up may result in loss of enrollment. By signing this **Childcare Consent and Waiver**, I acknowledge that I have read and understand it, and that I am in agreement with its provisions.

Signature of Parent or Guardian

Date

FOR STAFF USE ONLY

School Year **2019-20**

Classroom _____

Medical Release Form

Please Leave NO Blank Spaces

Child's Name: _____ Birth Date: _____

Child's Doctor: _____ Phone Number: _____

Preferred Dentist: _____ Phone Number: _____

Preferred Hospital: _____ Phone Number: _____

Insurance Information

Primary Insurance

Insurance Carrier: _____ Subscriber: _____

ID#: _____ Subscriber Date of Birth: _____

Group #: _____ Relationship to Subscriber: _____

Secondary Insurance

Insurance Carrier: _____ Subscriber: _____

ID#: _____ Subscriber Date of Birth: _____

Group #: _____ Relationship to Subscriber: _____

Please be sure that we have up-to-date emergency information at all times.

I hereby give permission for the Early Learning Campus to seek medical care, for my child/children, in the event of any medical emergency.

Signature of Parent or Guardian

Date

FOR STAFF USE ONLY

School Year **2019-20**

Classroom _____

Emergency Care

Should the need arise the following emergency treatment procedure will be followed:

- A trained and certified staff member will take whatever immediate steps necessary to stabilize the child's condition.
- If further care is needed, appropriate medical personnel will be contacted (i.e. 911)
- Staff will notify Caregiver/Guardian of situation as soon as possible

I have read and understand the above outlined emergency care procedures.

Signature of Parent or Guardian

Date



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School Year **2019-20**

Classroom _____

Allergy/Asthma Emergency Plan

Child's Name: _____ Birth Date: _____

Allergic to (List all allergies):

Asthmatic: Yes No

High Risk for Severe Reaction: Yes No

Please check the types of allergic/asthma reactions most likely experienced by your child. Check all that apply:

Asthma	Allergy	Symptom
<input type="checkbox"/>	<input type="checkbox"/>	Itching and Swelling of the lips, tongue, and/or mouth
<input type="checkbox"/>	<input type="checkbox"/>	Itching and/or a sense of tightness in the throat, hoarseness and hacking cough
<input type="checkbox"/>	<input type="checkbox"/>	Hives, itchy rash, and/or swelling about the face or extremities
<input type="checkbox"/>	<input type="checkbox"/>	Nausea, abdominal cramps, vomiting, and/or diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath, repetitive coughing, and/or wheezing
<input type="checkbox"/>	<input type="checkbox"/>	"Thready" pulse, "passing out"
<input type="checkbox"/>	<input type="checkbox"/>	Other (Please Describe): _____

Please indicate the plan that best addresses an allergic/asthmatic emergency should your child experience an allergic/asthmatic reaction.

If ingestion of food that brings on an allergic reaction is suspected or if the child has any of the above symptoms, do the following (CHECK ALL THAT APPLY):

- Administer prescribed epinephrine (EpiPen) immediately**
- Administer other prescribed medication:**
Medication and Dosage: _____
- Call 911**
- Call CAREGIVER**
Name and Telephone Number: _____
- Call Child's Doctor**
Name and Telephone Number: _____

By signing this form, I acknowledge that in order to protect my child from allergen exposure, my child's allergy information may be posted around the center. This will serve as a visual reminder to those who may interact with my child throughout the day.

Signature of Parent or Guardian

Date

Photo/Video Release Form

Child's Name: _____

Throughout the school year the Early Learning Campus (ELC) and other various organizations may visit and take pictures, video, and/or audio recordings of your child. These recordings may be used in your child's classroom, for group projects, published materials, written articles, etc. In order to allow your child to fully participate in these activities we require your signed consent. We understand that parents may have specific beliefs that may conflict with this request. Because of this, we ask that you select the following option most applicable to your family:

(PLEASE SELECT ONLY 1 OPTION)

_____ **All PHOTOGRAPHS ALLOWED**-I agree to allow my child to be audio recorded, videotaped, or photographed. I authorize the release of audio recordings, videotapes, or photographs for public viewing on local channels, for public showing, or for publication at the discretion of ELC.

_____ **CLASSROOM ONLY PHOTOGRAPHS ALLOWED**-I agree to allow my child to be audio recorded, videotaped, or photographed for my child's classroom use only. I understand that this may limit my child's participation in activities involving other University of Louisville departments and other outside organizations.

_____ **NO PHOTOGRAPHS ALLOWED**-I do not want my child to be audio recorded, videotaped, or photographed at this time. I understand that this includes photographs to be used inside the classroom, for art projects, etc. I also understand that this may limit my child's participation in activities involving other University of Louisville departments and other outside organizations.

By signing this form, I release ELC, its personnel, and any other persons from any liability connected with the tapings or use of such interviews, photographs, audio, or video recordings as I have given permission above.

Signature of Parent or Guardian

Date

*Please do not edit or alter this form in anyway.
Any concerns or questions may be directed to the Administration Team*



UNIVERSITY OF
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EARLY LEARNING CAMPUS

FOR STAFF USE ONLY:

School Year: **2019-20**

Classroom:

Walking Field Trip Permission Slip

Child's Name: _____

Throughout the school year, your child's class may take routine walking or buggy ride field trips on Early Learning Campus property (around the ELC and Family Scholar House buildings). These will only occur when weather permits and when your child has adequate outerwear (*i.e. jacket, hat, gloves for winter and sunscreen and hat for the summer*). The younger classes will be secured in buggies so that they may go on rides, while older classes may hold hands and walk in smaller groups. All classes will be supervised by at least two facilitators during these outings.

By signing this form, I give permission for my child to participate in these outings. I understand that participation is dependent upon how well my child is prepared for the weather. I will ensure my child has the proper outerwear in her/his cubby so that she/he may attend these walks throughout the year.

Signature of Parent or Guardian

Date



UNIVERSITY OF
LOUISVILLE

EARLY LEARNING CAMPUS

Sunscreen/Insect Repellent Authorization

Child's Name: _____

I understand that by signing this form, I give the Early Learning Campus permission to apply sunscreen to my child's skin, as needed, in order to protect against sun injury. I understand that it is my responsibility to provide sunscreen for this purpose and that any sunscreen or sun block provided will have an UVB and UVA protection of SPF 15 or higher. Any product that becomes expired will be returned to me to be disposed of in the manner that I see fit. This permission is valid until the product has been used in its entirety or it expires, whichever occurs first.

Additionally, I give permission for the application of insect repellents **only when public health authorities recommend due to a high risk of insect-borne disease** (*Lyme, etc.*). Repellent containing DEET will be used and shall be applied only on children older than two months. Staff will apply insect repellent no more than once per day.

Signature of Parent or Guardian

Date

Student Health History

Child's Name: _____ **Birth Date:** _____

Does your child have any of the following conditions? (Check correct answer)

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
ADD/ADHD			Cystic Fibrosis			Sinus Problems		
Allergies Seasonal/Drug			Dental Problems			Vision Problems		
Allergies Food/Insect			Diabetes Type I/Type II			Other: (Please Specify)		
- Epi-Pen			Orthopedic Impairment					
Anemia/Bleeding Problems			Earaches			Medications Taken Regularly:		
Anxiety/Depression			Headaches/Migraines			Purpose	Drug	Dose
Arthritis			Hearing/Speech Problems					
Asthma Mild/Mod/Sev			Heart Condition					
Bladder/Bowel Problems			Recent Surgery					
Cancer			Seizures					

If the answer to any of the above is YES, please explain:

Has the student visited the emergency room or hospital for this condition? Please explain:

Will your student need to take routine medications at school? **Yes** **No**

Has your child been or is your child currently involved in First Steps? **Yes** **No**

Has your child been or is your child currently involved in any kind of intervention therapy? **Yes** **No**

If yes, what type of services? (Check all that apply): **Occupational Therapy** **Physical Therapy**

Speech-Language Pathology **Developmental services** **Other** _____

Does your child have an Individual Family Service Plan (IFSP) or Individualized Education Plan (IEP)? **Yes** **No**

Signature of Parent or Guardian

Date

Signature of Physician

Date

Office Address

Phone Number

Please attach any additional instructions regarding child's special healthcare needs

COMMONWEALTH OF KENTUCKY CERTIFICATE OF IMMUNIZATION STATUS

Certificate Issuing Office Name and Address

Name of Child: _____ Birthdate: _____
(Last) (First) (Middle) (Suffix) (MM/DD/YYYY)

Name of Parent: _____
(Last) (First) (Middle) (Suffix)

Address: _____
(Street) (City) (State) (Zip Code)

VACCINE	DOSE 1 MM/DD/YYYY	DOSE 2 MM/DD/YYYY	DOSE 3 MM/DD/YYYY	DOSE 4 MM/DD/YYYY	DOSE 5 MM/DD/YYYY
Hepatitis B	/ /	/ /	/ /	/ /	/ /
Alt. Adult Hepatitis B ¹	/ /	/ /	/ /	/ /	/ /
DTaP/DTP/DT ²	/ /	/ /	/ /	/ /	/ /
Hib ³	/ /	/ /	/ /	/ /	/ /
Pneumococcal (PCV13)	/ /	/ /	/ /	/ /	/ /
Polio	/ /	/ /	/ /	/ /	/ /
Influenza	/ /	/ /	/ /	/ /	/ /
MMR	/ /	/ /	/ /	/ /	/ /
Varicella	/ /	/ /	Had Chickenpox or Zoster Disease Yes No		/ /
Hepatitis A	/ /	/ /	/ /	/ /	/ /
Meningococcal	/ /	/ /	/ /	/ /	/ /
Td	/ /	/ /	/ /	/ /	/ /
Tdap	/ /	/ /	/ /	/ /	/ /
Rotavirus	/ /	/ /	/ /	/ /	/ /
HPV	/ /	/ /	/ /	/ /	/ /
Men B	/ /	/ /	/ /	/ /	/ /
Pneumococcal (PPSV23)	/ /	/ /	/ /	/ /	/ /

¹Alternative two dose series of approved adult hepatitis B vaccine for adolescents 11 through 15 years of age. ²DTaP, DTP, or DT. ³Hib not required at 5 years of age or more.

- This child is current for immunizations until ____/____/____ (14 days after the next shot is due) after which this certificate is no longer valid, and a new certificate must be obtained.
- This child is not up-to-date at this time. This certificate is valid until ____/____/____ (14 days after the next shot is due) after which this certificate is no longer valid, and a new certificate must be obtained.

Reason child is not up-to-date:

- Provisional Status** - Child is behind on required immunizations.
- Medical Exemption** - The following immunizations are not medically indicated: _____

If Medical Exemption, can these vaccines be administered at a later date? No: _____ Yes: _____ Date: ____/____/____

Religious Objection

I CERTIFY THAT THE ABOVE NAMED CHILD HAS RECEIVED IMMUNIZATIONS AS STIPULATED ABOVE.

(Signature of physician, APRN, PA, pharmacist, LHD administrator, RN or LPN designee)

(Date)

This certificate should be presented to the school or facility in which the child intends to enroll and should be retained by the school or facility and filed with the child's health record.



CHILD ENROLLMENT FORM/INCOME APPLICATION

Participant Information: (To be completed by Parent/Guardian)

If a child is a SNAP/K-TAP recipient or a Foster/Head Start participant, the child is automatically eligible to receive free Program meal benefits, subject to the requirements of 7 CFR 226.23.

If your participant receives assistance from the items below, they are automatically eligible for free meals. (Please complete and skip to section 2.)

Participant's Last Name	Participant's First Name	Date of Birth <i>*If under 12 months, please complete Infant Addendum</i>	Meals Normally Eaten (Circle all that apply)	Head start	Foster	SNAP or K-TAP # List Entire SNAP or K-TAP CASE NUMBER Below
				<input type="checkbox"/>	<input type="checkbox"/>	
			B AM L PM S LN	<input type="checkbox"/>	<input type="checkbox"/>	
			B AM L PM S LN	<input type="checkbox"/>	<input type="checkbox"/>	
			B AM L PM S LN	<input type="checkbox"/>	<input type="checkbox"/>	
			B AM L PM S LN	<input type="checkbox"/>	<input type="checkbox"/>	

*Parent/Guardian works multiple shifts and participants may be in care different days/hours ___yes ___no

If child receives Head start services, please proceed to complete Section 2. Household Income is not required.

1. Income Application Household Members and Monthly Income:

NAMES OF HOUSEHOLD MEMBERS Including Children Not Listed Above Last, First	GROSS MONTHLY Income From Work (Before Deductions)	MONTHLY Income From Welfare Payments, Child Support, Alimony	MONTHLY Income From Pensions, Retirement, Social Security, Unemployment Compensation	Any Other MONTHLY Income Including Money Received from Kinship/Foster Child
1.	\$	\$	\$	\$
2.	\$	\$	\$	\$
3.	\$	\$	\$	\$

2. Signature and Social Security Number:

I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds and that deliberate misrepresentation may subject me to prosecution under applicable state and federal laws.

X _____
Signature of Adult Household Member Home/Cell Phone Number _____

X _____ No Social Security Number X _____
Last four digits Social Security Number* Date

FOR SPONSOR USE ONLY. DO NOT WRITE BELOW THIS LINE.

Application approved for: Free Meals SNAP/KTAP
 Reduced Meals Foster
 Paid Meals Headstart
 Income Household
 Total Household Monthly Income _____
 Household Size _____

Signature of Determining Official

Date

*7 CFR 226.15 (e)(2)

(Revised February 2018)

"The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The last four digits of the Social Security Number are not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for administration and enforcement of the Program."

USDA Nondiscrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

Parking Permit/ Vehicle Registration Form

In order to enhance security on our grounds, we ask that all regular pickups for ELC enrolled children display a parking permit on their vehicle. The static cling parking permit should be displayed on the bottom left corner of the vehicle's rear window. Please be sure to park only in ELC designated parking spaces. ELC designated parking is directly in front of the playground as shown on the attached map and is marked 'ELC'. All other spaces are reserved for Family Scholar House (FSH) residents. FSH may tow unauthorized vehicles at the owner's expense.

Enrolled Child/Family: _____

Vehicle	Make	Model	Color	License Plate Number	License Plate State
1					
2					
3					
4					
5					
6					

I have Allergies and/or Asthma...

Date: _____ My Name is: _____
I am in the _____
Classroom

I am allergic to: _____ I am asthmatic: Yes No

I am at High Risk for a reaction: Yes No

I have emergency medication: Yes No

I have an EpiPen / Inhaler / Nebulizer / Other: _____ (circle all that apply)

Please watch me for these symptoms:

Place Child's Photo Here



Please Note:

A child in this classroom is
allergic to:

Family Demographic Verification 2019-20

The Early Learning Campus certifies that this information is confidential and will only be used for demographic reporting in national accreditation, CACFP and KY All Stars Quality Rating reports.

Name of Person(s) Completing Form	
Child Name(s) Please list the names of the children who are enrolled at the ELC.	
Address	
Email Address(es)	
Contact Numbers	Home:
	Cell:
	Other:

Ethnicity Background

Please Indicate the Ethnicities of the following people:

	Name	Ethnicity (Check any that apply):
Mother		Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/>
Father		Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/>
Child #1:		Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/>
Child #2		Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/>
Child #3		Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/>

What Primary Language is spoken in the home? _____

Which nationality does the family most closely identify with? _____

Financial Background

Please list the occupations and place of employment for the parents/guardians of the student(s) being enrolled. **If either parent is a student, please list the academic institution where they are currently enrolled.**

Parent/Guardian Name	Occupation	Place of Employment

UofL Staff, Faculty, and **ALL** Students, please list your Student/Employee ID: _____

Please indicate the approximate annual household income:

- Less than \$15,000
- \$15,000-\$30,000
- \$30,000-\$50,000
- \$50,000-\$75,000
- \$75,000-\$100,000
- More than \$100,000

Educational Background

Please indicate the highest level of education completed for the parent(s) of the child applying:

Parent/Guardian Name	Highest Level of Education Completed
	Some High School <input type="checkbox"/> High School/GED <input type="checkbox"/> Some College <input type="checkbox"/> Associates <input type="checkbox"/> BA <input type="checkbox"/> MA <input type="checkbox"/> Ph.D <input type="checkbox"/> Technical Degree <input type="checkbox"/> <input type="checkbox"/> Other Graduate Degree (Please list): _____
	Some High School <input type="checkbox"/> High School/GED <input type="checkbox"/> Some College <input type="checkbox"/> Associates <input type="checkbox"/> BA <input type="checkbox"/> MA <input type="checkbox"/> Ph.D <input type="checkbox"/> Technical Degree <input type="checkbox"/> <input type="checkbox"/> Other Graduate Degree (Please list): _____

Based on your education, employment, skills, and/or interests are there any topics you would be interested in sharing with ELC students and/or staff? If so, what are they? _____

Signatures

PLEASE READ CAREFULLY BEFORE SIGNING

By signing this form, I understand that the University of Louisville's Early Learning Campus is relying on this information to prove household income in participation and partnership with national accreditation, CACFP, and KY All Stars Quality Rating reports. I certify that all information and answers to the above questions are true and complete to the best of my knowledge. I consent to the release of necessary demographic information if requested.

Signature

Date

Printed Name

Relationship to Child

Remind App Agreement

In an effort to improve our ability to communicate quickly and effectively with our families, we have selected an app called Remind to use as our immediate messaging system. The Remind app is used in more than 70% of U.S. public schools and was recommended to us by a member of our Parent/Facilitator Organization (PFO). The app will allow us to send text messages to any enrolled smartphone and will translate messages into more than 70 languages. We will be able to send messages to all families or by classroom as needed.

We will communicate major event reminders or emergency/unexpected information to our families via the app. We will continue to communicate more detailed daily operations information via classroom newsletters and periodic Director's Updates. If you would like to receive ELC messages via the Remind app, please complete the information below. Please complete one form per parent/guardian. When we receive your form, we will email the information on how to get set up in Remind.

Please print clearly.

Child's Name: _____ Classroom: _____

Parent/Guardian Name: _____

Parent/Guardian Cell Number: _____

Parent/Guardian email: _____

I request to enroll as a member of the ELC Remind app. I understand that:

- The app is advertised as secure but that Parents/Guardians enroll for the Remind system at their own risk
- Neither the ELC nor the University of Louisville accepts responsibility for any unauthorized access to contact information
- Standard text messaging rates may apply depending upon my cell phone plan
- I will remain enrolled until my child leaves the ELC or until I submit a written request to withdraw

Parent/Guardian Signature

Date

By checking this box, I elect to receive Remind notices from the ELC Family Organization

2019-20 ELC Enrollment Agreement

Parent/Guardian: _____
Child: _____ Classroom: _____ Weekly Tuition Rate: _____

Please note that the Turtles classroom will begin the year with eight older infants. When the youngest child reaches 12-months, the classroom will become a toddler classroom with a total of 12 children.

Tuition Rates and Fees

1. The annual re-enrollment fee of \$50 per child for returning students is due by *Wednesday, August 14 2019*.
2. If your child is new to the ELC, the tuition deposit of \$240.00 is due immediately to secure your child's space. A written two-week advance notice of your child's last week of care is required to receive a refund via invoice credit. We cannot hold a space for longer than 48 hours after an offer is made because we have many families who are waiting to be enrolled.
3. Payments may be made by check or money order.
- 4.. Your weekly tuition will remain the same unless notified by the ELC. Each week's tuition is due by the end of business (6:00 PM) on Friday for care in the coming week, whether or not you receive an invoice. In the 2019-20 school year, children will not be admitted if payment is delinquent. Accounts in arrears may lead to termination of enrollment and subsequent collection action at parent/guardian expense.
5. Weeks with holidays, inclement weather closings, and child absence due to illness will be billed at the full weekly rate. The ELC will not charge tuition for the following weeks of planned closures: Winter Break and Staff Training Week.
6. Non-Family Scholar House (FSH) children are entitled to two weeks of vacation after 6 months of enrollment and must be requested in 5 day increments at least one week in advance (elcbusi@louisville.edu). Vacation credits will be applied to the invoice of the vacation week(s). Parents of FSH children should consult with FSH to determine potential vacation weeks.
7. Parents or authorized adults (as listed in advance on the Authorized Pick Up Form) must pick up children before the ELC closing time of 6:00 PM. Late pickups will result in a fee of \$15 for every 5 minutes after 6:00 PM. Late fee payments are due the following business day. Repeated late pick-ups may result in discontinuation of care.
8. Families must use access cards to enter the building rather than ringing the bell. Access cards are \$15 each. Initial cards are billed on the next tuition invoice.
9. The ELC is open 12-months of each year. Families must provide at least two-week's written notice of withdrawal. Failure to provide two-week's advance written notice of withdrawal will result in continuing tuition charges and possible collection action as the expense of the parent or guardian.
10. Parents/Guardians who receive child care subsidies (e.g., 3Cs) are responsible for complying with subsidy program requirements, monitoring contract amounts and expiration dates, knowing and paying unsubsidized portions of the tuition, and ensuring timely contract renewals. It is the parent/guardian's responsibility to pay any co-pay amounts or fees not covered by the subsidy program each week in advance of care for the following week. Any unsubsidized portion of each week's tuition is due by the end of business (6:00 PM) on Friday for care in the coming week, whether or not you receive an invoice. In the 2019-20 school year, children will not be admitted if payment is delinquent. Accounts in arrears may lead to termination of enrollment and subsequent collection action at parent/guardian expense.

2019-20 ELC Enrollment Agreement (Continued)

Required Documentation

1. A completed Enrollment Packet for each child is due by Wednesday, July 24, 2019.
2. All immunization records must be current. Children will not be admitted if the immunization record is expired per state licensing guidelines. It is the parent/guardian's responsibility to monitor expiration dates and obtain a new immunization record before the previous record expires.

Daily Schedule

1. ELC hours of operation are Monday-Friday from 7:00 AM – 6:00 PM. Children, except infants, must be dropped off no later than 9:45 AM.
2. Two late passes per semester (August –December, January – April, May – July) are allowed. Late arrivals in excess of two per semester will result in no entry for the day. Late entry for medical and other appointments is permissible with documentation from that entity without using an ELC late pass.

My signature confirms I have read, understand, and agree to the aforementioned Enrollment Agreement:

Parent/Guardian: _____ Date: _____

Parent/Guardian: _____ Date: _____

EARLY LEARNING CAMPUS

FAMILY HANDBOOK

STATEMENT OF UNDERSTANDING

My signature(s) indicates that I have read the Early Learning Campus Family Handbook and understand and agree to the policies and procedures described herein. I understand that the Family Handbook is subject to change with or without notice and that updated versions are available on the Early Learning Campus Website at Louisville.edu/education/elc.

SIGNATURE OF PARENT/GUARDIAN #1 DATE

SIGNATURE OF PARENT/GUARDIAN #2 (IF APPLICABLE) DATE

(Please sign and return with other application documents for your child.)

INFANT ADDENDUM TO ENROLLMENT

Dear Parent:

This child care center participates in the USDA Child & Adult Care Food Program (CACFP). This program provides reimbursement to the center for creditable meals served to your infant while in our care. We want to work with you to provide the very best nutritional care for your baby. Under the CACFP regulations, the center may NOT charge you a separate fee for meals that are claimed for reimbursement.

We use the meal pattern below, which was developed by the USDA for centers participating in the CACFP. The type and amount of foods served vary according to the age of the infant. However, the actual foods we provide will be based on what you tell us about your baby's own food needs.

Age	Breakfast	Lunch and Supper	Snack
Birth through 5 months	4-6 fluid ounces formula or breast milk	4-6 fluid ounces formula or breast milk	4-6 fluid ounces formula or breast milk
6-11 months	6-8 fluid ounces formula or breast milk 0-4 tablespoons infant cereal, meat, fish, poultry, whole egg, cooked dry beans, or cooked dry peas; or 0-2 ounces of cheese; or 0-4 ounces (volume) of cottage cheese; or 0-4 ounces or 1/2 cup of yogurt; or a combination of the above 0-2 tablespoons vegetable or fruit or a combination of both	6-8 fluid ounces formula or breast milk 0-4 tablespoons infant cereal, meat, fish, poultry, whole egg, cooked dry beans, or cooked dry peas; or 0-2 ounces of cheese; or 0-4 ounces (volume) of cottage cheese; or 0-4 ounces or 1/2 cup of yogurt; or a combination of the above 0-2 tablespoons vegetable or fruit or a combination of both	2-4 fluid ounces formula or breast milk 0-1/2 slice bread or 0-2 crackers or 0-4 tablespoons infant cereal or ready-to-eat breakfast cereal 0-2 tablespoons vegetable or fruit, or a combination of both

Talk with your health care provider and let us know whether you want to use breast milk or a formula while your child is in the center's care. We also need to know when you will introduce solid foods to your infant. You may choose for us to provide the formula, or you may provide the formula for your infant.

The Early Learning Campus
currently provides the following formula(s): Meijer Gentle Formula

Please fill out the form below and return it to help us plan the meals for your infant. If this information changes, you will need to complete a new form.

Sincerely,

May Hays (502) 852-4496 6-28-19
Sponsor Representative Phone Number Date

MUST BE COMPLETED BY PARENT GUARDIAN

Infant Name _____	Infant Birthdate ____/____/____
Check all that apply:	
<input type="checkbox"/> Parent will breast-feed the infant at the day care center or provide expressed breastmilk or iron fortified formula	
<input type="checkbox"/> Parent will provide additional baby food	
<input type="checkbox"/> Parent will provide iron fortified formula, breast milk and Center will provide Additional baby food	
<input type="checkbox"/> Center will furnish all iron fortified infant formula	
<input type="checkbox"/> Center will furnish all iron fortified infant formula and additional baby food	
Parent/Guardian Signature _____	Date _____
PLEASE NOTE: Parents may provide their own infant formula or their choice of one infant food item per day. Please speak to the Center's Director if you wish to make other arrangements.	

*7 CFR 226.20(b)(5)

TODDLER TRANSITION PLAN

Kentucky's Child Care Regulations state that children who are toddlers (defined as under 36 months) must not be blended with older children for care. While all of the children in your child's classroom will begin the school year under three-years, most will turn three-years at some point during the school year. We intentionally created a narrow, five-month age range in the Travelers, Dreamers, and Caterpillars Classrooms so that the children have very similar educational and care needs. It is our belief that children are more successful when they are allowed to remain in the same room with their friends, as opposed to being promoted one at a time into a new classroom when they have their third birthdays.

As the children enrolled in these classrooms celebrate their third birthdays, our staff will ensure that the classroom is continuously updated so that programming and equipment are age and developmentally appropriate for the entire group. Instead of promoting your child to a new classroom on their third birthday, they will remain together in the assigned classroom (Travelers, Dreamers, or Caterpillars) for the school year unless an opening becomes available in an older classroom and it is a better fit for the child's individual needs.

Please complete the release acknowledging that you agree that the provided classroom assignment is the correct placement for your child.

Child's Name _____

Assigned Classroom _____

Parent Printed Name _____

Parent Signature _____

Date of Signature _____

KENTUCKY'S CHILD CARE REGULATION

922 KAR 2:120
Section 5. Infant and Toddler Play Requirements. (1) Infant and toddler inside areas shall:
(3) A toddler may participate in an activity with an older child for more than one (1) hour per day if:
(a) The toddler is in transition to the pre-school age group;
(b) The toddler is twenty-one (21) months or older;
(c) Space for the toddler is available in the preschool-age group;
(d) The staff-to-child ratios and group sizes are maintained based on the age of the youngest child;
(e) The center has a procedure for listing a transitioning toddler on attendance records, including a specific day and time the toddler is with either age group; and
(f) The child care center has obtained the signature and approval of the toddler's parent on the toddler's transition plan.