COMMUNITY CH CARE CENTER

Head Start/EHS/ECEAP/Child Care

FOR OFFICE USE ONLY
DEPOSIT PAID $_____DATE_____
DISENROLLMENT DATE_____
☐ FOOD ALLERGY
☐ HEALTH CONDITION
☐ SOCIAL / FAMILY CONCERN

EMERGENCY AND MEDICAL INFORMATON FORM

Child's Name _____ Birthday _____ Gender_____ Start Date_____

School Age Children Only_____
School Grade

Primary residence of child is with: _____

Are there any court orders/parenting plans in effect concerning the custody of the child? ☐Yes ☐No
If so, please provide us with a copy of these documents prior to enrollment.
Is your family currently involved with the State of Washington Department of Children, Youth & Families (CPS)?
☐ Yes ☐ No

Legal Guardian Name ( ) Home Phone ( ) Cell Phone Email Address

Address of Guardian Place of Employment ( ) Work Phone

The best way to reach me (i.e. email, text, phone call) The best time to reach me

Legal Guardian Name ( ) Home Phone ( ) Cell Phone Email Address

Address of Guardian Place of Employment ( ) Work Phone

The best way to reach me (i.e. email, text phone call) The best time to reach me

Local Emergency Contacts (These persons are authorized to pick up the child):

1. Name Relationship to Guardian ( ) Phone Number(s)

2. Name Relationship to Guardian ( ) Phone Number(s)

Physician/Dentist Information:

Physician Name ( ) Phone Last Appt. Date Dentist Name ( ) Phone Last Appt. Date

*(if you do not have a Doctor or Dentist please let our staff know and we can provide you with a list of local providers)

Medical Insurance Information:

Company: _____ Plan Number: _____

Allergy & Medical History

Allergies, medication/medical conditions_____ **If none, check here** _____

Permission for Emergency Treatment

At the time of an emergency, medical treatment is urgent. I authorize Community Child Care Center staff to call emergency aid (911) or transport my child to the nearest hospital or my child's physician to receive immediate care. I also give permission for CCCC to give first aid for minor injuries. I understand that I will be responsible for all expenses connected with the seeking of emergency care.

Signature _____ **Date**_____

Revised 2020

COMMUNITY CHILD CARE CENTER
530 NW Greyhound Way Pullman, WA. 99163 (509) 334-9290
Head Start/EHS/ECEAP/Child Care

PARENT CONSENT FORM

Child's Name

I give permission for the following services to be provided to my child. I understand that by circling "yes," permission is granted for the specific service and by circling "no," permission is <u>not</u> granted and my child will be excluded from the activity.

Example of specific tools:

0-3 year old children receive: **Ages and Stages Developmental Checklist** **Teaching Strategies Gold Developmental Assessment** **Hearing, vision, height, & weight screenings**	**3-5 year old children receive:** **ESI-R** – *Motor, Cognitive, and Language Screen designed to identify children who may be in need of further developmental evaluation* ***Teaching Strategies Gold Dev. Assessment*** **Hearing, vision, height, & weight screenings**

<u>Yes / No</u> - I grant permission for my child to receive all standard screenings and assessments used by the program, age appropriate for my child. These tools are used to assess children in the areas of language and cognition, visual and auditory, fine and gross motor, physical growth, and social/emotional development. The results will be used to plan appropriate curriculum for your child, and determine the need for any further evaluations. All results are shared with parents.

<u>Yes / No</u> - I grant permission for an employee to **apply sunscreen (Banana Boat SPF 30 or higher), lip balm, lotion and/or diaper ointment (A+D Diaper Ointment)** if applicable to my child when necessary.

<u>Yes / No</u> – I grant permission for my child to use hand sanitizers or hand wipes with alcohol (if over 24 months) when necessary.

<u>Yes / No</u> - I grant permission for my child to use toothpaste with fluoride daily (if over 24 months) and receive **dental screening/fluoride** application from a registered dental hygienist

<u>Yes / No</u> - I grant permission for my child to be **photographed or videotaped** by staff and/or child care parents.

<u>Yes / No</u> - I grant permission for my child's **photographs to be hung up in the classrooms.**

<u>Yes / No</u> - I grant permission for **pictures or videotapes** of my child be taken and used in **advertising, newspapers, newsletters, displays, CCCC's FACEBOOK page**, or other types of educational/promotional publications.

<u>Yes / No</u> - I grant permission for my child to leave the school premises under the supervision of staff members for visits to close-by parks and **field trips** in an authorized vehicle with a notice ahead of time.

<u>Yes / No</u> - I grant permission for CCCC/HS/EHS/ECEAP to provide transportation for my child. I hereby give permission to the staff to sign my child in and out of the program when my child is being **transported by CCCC and during emergency situations (e.g. COVID-19 pandemic).** Washington state law requires parents to sign their children in upon **arrival and upon departure** out of the center.

<u>Yes / No</u> - I grant permission for CCCC and Whitman County Health Department to **share** information regarding my child's health.

<u>Yes / No</u> - I grant permission for administrators, teaching staff, and regulatory authorities, on request, to **access my child's file**. I understand that as a parent or legal guardian, I also will be granted immediate access to my child's records upon request.

<u>Yes / No</u> - I grant permission for CCCC to access my child's immunization record through the Washington Immunization Information System to assist with accessing and determining my child's immunization status.

Parent Signature _____ Staff Signature _____ Date _____

COMMUNITY CHILD CARE CENTER
TUITION INFORMATION / AGREEMENT
COLFAX
Effective date: September 1, 2022

Child's Name: _____ **Siblings:**_____

Person responsible for paying tuition / copayment:_____

Address:_____

Source of payment: **Personal funds**_____ **DSHS Subsidy**_____ **Financial Aid/Loans**_____

Tuition is to be paid in advance and is due by the 10th of the month. Any account not paid in full by the 1st of the following month may be assessed a late fee of 1.5% on the balance. You will be charged a monthly rate (see below) based on the schedule that you need. Any changes to the schedule must be given to us with as much advance notice as possible. New tuition rates take affect September 1st. Parents will be notified in writing of any changes in fees at least four weeks in advance. **You can receive a 3% discount if you sign up to make your payments electronically with your bank account. We also accept checks, credit and debit card payments.**

Tuition Policy: There will be no tuition credit given for occasional days missed, holidays that CCCC is closed or personal vacation days. During extended leaves, CCCC will provide a 50% tuition discount to children who are absent for 3 or more consecutive weeks. If a child is absent for one month or more, no tuition will be charged.

Community Child Care Center accepts DSHS subsidized childcare. Arrangements must be made by the parent/guardian through DSHS. Children accepted on subsidized childcare must have written verification on file with CCCC prior to enrollment. Parents/guardians are responsible for any hours of service beyond DSHS authorizations and all co-payments as well as any late fees or fines.

Parents need to call when their child will be absent from the center.

Our operating hours are **7:30 a.m. to 5:30 p.m**. We need parents to respect these hours.

Late Charges: We will charge $15.00 per child for any pickup time between 5:30pm-5:45pm. Each minute after 5:45pm will be charged $1.00 a minute per child.

School Year 2022/2023 tuition:

Days per week:	5	4	3	2	1
Tuition per month:					
Full time	$960	$765	$575	$385	$195
Part time (5 hrs / day)	$520	$420	$315	$210	$115
After School	$350	$290	$220	$152	$85
Before School (7:30 - 8:05)	$57	$47	$37	$27	$17
If less than 5 days per week, please indicate which days your child will attend:					
	M	T	W	TH	FR

Drop-in rates will be $9.50 per hour.
Please call to check on availability before dropping off your child!

Please circle above and/or indicate here what schedule you will need for this school year:_____

I have read the above agreement and accept the conditions stated herein. I have received the parent handbook, which includes important policies and procedures including the Internal Disaster Plan and Pesticide Policy.

Signature _____ **Date**_____
Parent/Legal Guardian

Child and Adult Care Food Program
SAMPLE LETTER TO PARENTS
Child Care Centers

Dear Parents:

Our center does not charge separately for meals because it participates in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). This program pays centers for nutritious meals served to all children while in care.

How much does the center receive in payment for meals served to my child while in care?
The amount of payment received is based on the income status of the families in our center. We receive a higher payment for those families that are low-income.

How do you determine the income status of my family?
The information you provide on the enclosed Enrollment/Income-Eligibility Application determines the income status and payment level.

I'm not sure if my family income qualifies. How do I decide?
If your gross income (before deductions) is the same as or less than the amount on the line for your family size on the income guidelines table below, the center is eligible for the higher payment for your child(ren). When self-employed, net income may be reported. **Please complete the Enrollment/Income Eligibility Application in ink and return it to our office as soon as possible.**

Income Guidelines
Reduced-Price Meals
Effective July 1, 2022–June 30, 2023

Household Size	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	$25,142	$2,096	$1,048	$967	$484
2	$33,874	$2,823	$1,412	$1,303	$652
3	$42,606	$3,551	$1,776	$1,639	$820
4	$51,338	$4,279	$2,140	$1,975	$988
5	$60,070	$5,006	$2,503	$2,311	$1,156
6	$68,802	$5,734	$2,867	$2,647	$1,324
7	$77,534	$6,462	$3,231	$2,983	$1,492
8	$86,266	$7,189	$3,595	$3,318	$1,659
For each add'l family member, add:	$8,732	$728	$364	$336	$168

If I receive payment from DSHS for child care, should I complete these forms?
Yes. DSHS payments for child care do not qualify a family for the higher payment.

If my household income is greater than the income guidelines for reduced-price meals, or if I choose not to report my income, what should I do?
You should complete Parts 1 and 5 and may write "above-scale" in Part 4.

If I choose not to report my household income, do I still need to return the Enrollment/Income-Eligibility Application?
Yes. If you choose not to fill out the income portion of the Enrollment/Income Eligibility Application (E/IEA), you must still complete Part I, the "Children's Information" section, and Part 5. Federal regulations require that all child care centers collect information on the normal days and hours child(ren) are expected to be in care and the expected meals to be received.

Is there another way for the center to receive the higher payment other than using my family income?
Yes. Your child(ren) may be eligible for the higher payment based on one of the following:

1. You receive Basic Food, Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR) for any member of your household.
2. Your child is a foster child.

If a household member currently receives benefits from one of these programs, or I believe my family income would qualify my child, what should I do?
Complete the attached Enrollment/Income-Eligibility Application, following the directions on the form. There is a separate section for each way your child may qualify.

Will this information be kept confidential?
Yes. The information will be made available only to a limited number of our staff or employees of the Office of Superintendent of Public Instruction, U.S. Department of Agriculture, or the U.S. General Accounting Office when they are reviewing our program.

Will the center make menu substitutions for my child?
If your child has been determined by a doctor to be disabled, and the disability would prevent the child from eating the regular meals at the center, we will make any substitutions prescribed by the doctor at no extra charge.

What do I need to bring to the center if my child needs menu substitutions?
You must bring the doctor's note that prescribes the alternative foods needed and verifies special meals are needed due to the disability.

Whom should I contact if I have any questions?
Contact our office at 509-334-9290.

Thank you for helping us provide healthy meals for your child.

Sincerely,
Mary McDonald
Executive Director

Child and Adult Care Food Program
ENROLLMENT/INCOME-ELIGIBILITY APPLICATION

PART 1 – CHILDREN'S INFORMATION—Required for all children in care.

Child's Name	Birthdate	Age	Circle Normal Days/ Print Normal Hours of Care	Circle Meals and Snacks Normally Received
			Sun Mon Tu Wed Th Fri Sat Normal Hours ______ to ______	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ______ to ______	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ______ to ______	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ______ to ______	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack

INCOME ELIGIBILITY

Please check the boxes that apply to help determine the other parts of this form to complete:

☐ A family member in our household receives benefits from Basic Food, TANF, or FDPIR. (Please complete Part 2 and 5.)

☐ One or more of the children in Part 1 is a foster child. (Please complete Part 3 and 5.)

☐ My child(ren) may qualify for Free/Reduced-Price meals based on household income. (Please complete Part 4 and 5.)

☐ My child(ren) will not qualify for Free/Reduced-Price meals. (Please complete Part 5 only.)

PART 2 – HOUSEHOLD MEMBER RECEIVING BASIC FOOD/TANF/FDPIR— Any household member receiving benefits can establish eligibility for all children in the household.	Case Number or Identification Number

PART 3 – FOSTER CHILDREN—List the names of any children listed in Part 1 who are foster children.

PART 4 – TOTAL HOUSEHOLD GROSS INCOME FROM LAST MONTH—Not required if you have reported a case number in Part 2.

Tell us how much and how often. If no income, write "0". Use net income if self-employed.

List names (First and Last) of everyone in your household, including foster children	Earnings from Work Before Deductions	Weekly	Every 2 Weeks	2X Month	Monthly	Welfare, Alimony, Child Support	Weekly	Every 2 Weeks	2X Month	Monthly	Retirement, Pensions, Social Security, Other	Weekly	Every 2 Weeks	2X Month	Monthly
1.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
2.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
3.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
4.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
5.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
6.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐

PART 5 – SIGNATURE AND CERTIFICATION—REQUIRED

The adult household member who fills out the application must sign below. If Part 4 is completed, the adult signing the form must also list the last four digits of his/her Social Security Number (SSN) or check the box if no SSN. *See Privacy Act Statement on the back of this page.*

If you have listed a case number in Part 2 or are applying on behalf of a foster child, or have checked the box that your child(ren) will not qualify for Free/Reduced-Price meals, the last four digits of the SSN is not needed.

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Signature of Adult	Today's Date	Print Name of Adult Signing
X______________________	____________	Social Security Number (SSN) (last four digits) XXX-XX- ☐ Check if no SSN
Address	City/State/Zip Code	Daytime Phone

PART 6 – CHILDREN'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Multi-Racial
☐ Native Hawaiian or Pacific Islander ☐ White

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, the funds your child care center/provider receives may be impacted. 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 is not required when you apply on behalf of a foster child or you list a Basic Food, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child 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 the meal reimbursement for your child care center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

MAIL*: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or

FAX: (833) 256-1665 or (202) 690-7442; or
EMAIL: program.intake@usda.gov

***Only use this address if you are filing a complaint of discrimination.**

This institution is an equal opportunity provider.

DO NOT FILL OUT - CENTER USE ONLY

☐ Child(ren) are categorically free based on Basic Food/TANF/FDPIR.

☐ Foster child(ren) have been identified on this form and qualify for the free category.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

☐ Child(ren) on this form who are not categorically eligible qualify as follows:
Check one: ☐ Free
☐ Reduced-Price
☐ Above-Scale

Total Income: $_____
☐ Annual ☐ Monthly ☐ Twice Per Month
☐ Every Two Weeks ☐ Weekly

X_____ _____
Signature of Institution's Representative **Today's Date**

NOT VALID WITHOUT SIGNATURE AND DATE.

EIEA Effective Date: If the institution is using the parent/guardian signature date as the effective date, the form must have been signed by the institution representative within the same month the parent signed the form or the immediately following month. If the institution representative does not evaluate and sign the EIEA within these guidelines, the institution representative's signature date must be used as the effective date.

Certificate of Immunization Status (CIS)

Washington State Department of Health

Reviewed by: Date:
Signed COE on File? ☐ Yes ☐ No

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

Child's Last Name:	First Name:	Middle Initial:	Birthdate (MM/DD/YYYY):

I give permission to my child's school/child care to add immunization information into the Immunization Information System to help the school maintain my child's record.	Conditional Status Only: I acknowledge that my child is entering school/child care in conditional status. For my child to remain in school, I must provide required documentation of immunization by established deadlines. See back for guidance on conditional status.
X _____ Parent/Guardian Signature Date	X _____ Parent/Guardian Signature Required if Starting in Conditional Status Date

▲Required for School • Required Child Care/Preschool	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY
Required Vaccines for School or Child Care Entry						
•▲ DTaP (Diphtheria, Tetanus, Pertussis)						
▲ Tdap (Tetanus, Diphtheria, Pertussis) (grade 7+)						
•▲ DT or Td (Tetanus, Diphtheria)						
•▲ Hepatitis B						
• Hib (*Haemophilus influenzae type b*)						
•▲ IPV (Polio) (any combination of IPV/OPV)						
•▲ OPV (Polio)						
•▲ MMR (Measles, Mumps, Rubella)						
• PCV/PPSV (Pneumococcal)						
•▲ Varicella (Chickenpox) ☐ History of disease verified by IIS						
Recommended Vaccines (Not Required for School or Child Care Entry)						
Flu (Influenza)						
Hepatitis A						
HPV (Human Papillomavirus)						
MCV/MPSV (Meningococcal Disease types A, C, W, Y)						
MenB (Meningococcal Disease type B)						
Rotavirus						

Documentation of Disease Immunity (Health care provider use only)

If the child named in this CIS has a history of varicella (chickenpox) disease or can show immunity by blood test (titer), it must be verified by a health care provider.

I certify that the child named on this CIS has:
☐ A verified history of varicella (chickenpox) disease.
☐ Laboratory evidence of immunity (titer) to disease(s) marked below.

☐ Diphtheria	☐ Hepatitis A	☐ Hepatitis B
☐ Hib	☐ Measles	☐ Mumps
☐ Rubella	☐ Tetanus	☐ Varicella

☐Polio (all 3 serotypes must show immunity)

▶

Licensed Health Care Provider Signature Date

▶

Printed Name

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

Health Care Provider or School Official Name: _____ Signature: _____ Date: _____
If verified by school or child care staff the medical immunization records must be attached to this document.

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

To print with the immunization information filled in:
Ask if your health care provider's office enters immunizations into the WA Immunization Information System (Washington's statewide registry). If they do, ask them to print the CIS from the IIS and your child's immunization information will fill in automatically. You can also print a CIS at home by signing up and logging into MyIR at https://wa.myir.net. If your provider doesn't use the IIS, email or call the Department of Health to get a copy of your child's CIS: waiisrecords@doh.wa.gov or 1-866-397-0337.

To fill out the form by hand:
1. Print your child's name and birthdate, and sign your name where indicated on page one.
2. Write the date of each vaccine dose received in the date columns (as MM/DD/YY). If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guides below to record each vaccine correctly. For example, record Pediatix under Diphtheria, Tetanus, Pertussis as DTaP, Hepatitis B as Hep B, and Polio as IPV.
3. If your child had chickenpox (varicella) disease and not the vaccine, a health care provider must verify chickenpox disease to meet school requirements.
   - ☐ If your health care provider can verify that your child had chickenpox, ask your provider to check the box in the Documentation of Disease Immunity section and sign the form.
   - ☐ If school staff access the IIS and see verification that your child had chickenpox, they will check the box under Varicella in the vaccines section.
4. If your child can show positive immunity by blood test (titer), have your health care provider check the boxes for the appropriate disease in the Documentation of Disease Immunity section, and sign and date the form. You must provide lab reports with this CIS.
5. Provide proof of medically verified records, following the guidelines below.

Acceptable Medical Records
All vaccination records must be medically verified. Examples include:
- A Certificate of Immunization Status (CIS) form printed with the vaccination dates from the Washington State Immunization Information System (IIS), MyIR, or another state's IIS.
- A completed hardcopy CIS with a health care provider validation signature.
- A completed hardcopy CIS with attached vaccination records printed from a health care provider's electronic health record with a health care provider signature or stamp. The school administrator, nurse, or designee must verify the dates on the CIS have been accurately transcribed and provide a signature on the form.

Conditional Status
Children can enter and stay in school or child care in conditional status if they are catching up on required vaccines for school or child care entry. (Vaccine series doses are spread out among minimum intervals, so some children may have to wait a period of time before finishing their vaccinations. This means they may enter school while waiting for their next required vaccine dose). To enter school or child care in conditional status, a child must have all the vaccine doses they are eligible to receive before starting school or child care.

Students in conditional status may remain in school while waiting for the minimum valid date of the next vaccine dose plus another 30 days time to turn in documentation of vaccination. If a student is catching up on multiple vaccines, conditional status continues in a similar manner until all of the required vaccines are complete.

If the 30-day conditional period expires and documentation has not been given to the school or child care, then the student must be excluded from further attendance, per RCW 28A.210.120. Valid documentation includes evidence of immunity to the disease in question, medical records showing vaccination, or a completed certificate of exemption (COE) form.

Reference guide for vaccine trade names in alphabetical order For updated list, visit https://www.cdc.gov/vaccines/terms/usvaccines.html

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB	Hib	Fluarix	Flu	Havrix	Hep A	Menveo	Meningococcal	Rotarix	Rotavirus (RV1)
Adacel	Tdap	Flucelvax	Flu	Hiberix	Hib	Pediarix	DTaP + Hep B + IPV	RotaTeq	Rotavirus (PV5)
Afluria	Flu	FluLaval	Flu	HibTITER	Hib	PedvaxHIB	Hib	Tenivac	Td
Bexsero	MenB	FluMist	Flu	Ipol	IPV	Pentacel	DTaP + Hib +IPV	Trumenba	MenB
Boostrix	Tdap	Fluvirin	Flu	Infanrix	DTaP	Pneumovax	PPSV	Twinrix	Hep A + Hep B
Cervarix	2vHPV	Fluzone	Flu	Kinrix	DTaP + IPV	Prevnar	PCV	Vaqta	Hep A
Daptacel	DTaP	Gardasil	4vHPV	Menactra	MCV or MCV4	ProQuad	MMR + Varicella	Varivax	Varicella
Engerix-B	Hep B	Gardasil 9	9vHPV	Menomune	MPSV4	Recombivax HB	Hep B		

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

COMMUNITY CHILD CARE CENTER
530 NW Greyhound Way Pullman, WA 99163 (509) 334-9290
Head Start/EHS/ECEAP/Child Care

CCCC Health History Form (1-5 years)

Child's Name (Last, First, Middle)	Sex	Birth Date (MM/DD/YY)	Country of Birth

Health History

Name of child's Health Care Provider			
Name of child's Dentist			
		Child's Weight at Birth: Pounds_____ Ounces_____ Grams_____	
		Type of Delivery:	
Yes	**No**	**Please Answer the Following:**	
		Were you told your child was born early or premature? How Early?	
		Were drugs, alcohol or cigarettes part of family life during pregnancy?	
Does your child have any of the following?			
Yes	**No**	**Health Concerns**	**If yes, Describe:**
		1. Anemia	
		2. **Breathing Problems*** (Asthma, RSV, RAD, other) Must answer the question on the right. Do not leave blank.	When was the last time your child had to use medication for the breathing problem? _____ Has your child been hospitalized overnight two or more times in the past year for breathing problems? ☐Yes ☐No Has your child been seen in the emergency room three or more times in the past year for breathing problems? ☐Yes ☐No Comments:
		3. Bowel/bladder problems	
		4. **Diabetes***	
		5. Frequent ear aches or infections	
		6. Hearing Concerns	
		7. **Heart Conditions***	
		8. Frequent nose bleeds	
		9. **Seizures***	

Child Health Plan Required/Potentially life-threatening condition

Yes	No	Health Concern	Is Yes, Describe:
		10. Skin condition	Is medication or lotion applied at home?? ☐Yes ☐No Are there things to avoid (e.g. certain soaps, grass, water play)? ☐Yes ☐No Comments:
		11. Tuberculosis Exposure	
		12. Walking/climbing difficulties	
		13. Vision concerns/wears glasses	
		14. Secondhand smoke exposure	
		15. Lead Exposure a. Lived in a house with peeling paint built before 1978? b. Has a sibling/relative or close friend with lead poisoning? c. Lives with an adult whose job or hobby involves lead? (i.e. welding, stained glass or pottery) d. Lived near a smelter/battery plant/car repair shop or other lead related industry? e. Have you or your family used home remedies such as azareon, greta, kohl, or pavlooah? (Circle all that apply).	
		16. Has your child ever been tested for lead?	
		17. Other health concerns? (Please List)	
		18. Has your child experienced any of the following? Chicken Pox, Measles, Mumps, Whooping Cough, other? Please describe.	
		19. Has your child experienced any serious illness/injury, surgery, or seen a specialist? If yes, when and for what?	
		20. Is tobacco currently in use in your home (i.e. smokeless tobacco, cigars, pipe, cigarettes?	
		21. Are drugs currently in use in your home? If yes, what does this look like?	
		22. Is alcohol currently used in your home? If yes, what does this look like?	
		23. Has your child been exposed to violence in the home?	
Time (Hours)		24. How much time does your child spend being physically active each day? (running, jumping, dancing, etc.)	
Time (Hours)		25. How much time does your child spend each day watching TV/videos, playing computer/gaming systems, on tablet?	

Child's Name:

Yes	No	Please answer the following:
		26. When riding in a car/truck, does your child use a car seat/booster?
		27. When your child rides a bike/trike, does he/she wear a helmet?

Non-Food Allergies

28. Does your child have allergies or severe reactions to any of the following: ☐Yes ☐No
If yes, please check only those that apply:
☐**Insect Bites/bee stings*** ☐Animals ☐Pollens/Hay Fever ☐Medications ☐Other
(Please Specify)

Please describe your child's allergic reaction:

How do you treat your child's allergy?

Has the allergy been diagnosed by a doctor? ☐Yes ☐No

Child Health Plan Required/Potentially life-threatening condition

Medications

Yes	No	Please answer the following:
		29. Does your child take any medications? Please list ALL medications:
		30. Will your child need to take any medications during scheduled programming? (Staff: Please review Medication Administration Procedure; additional action required)

Dental

Yes	No	
		31. Has your child complained about pain in the teeth or gums? If yes, please describe:
		32. Does your child use fluoride toothpaste at home?
		33. How many times per day does your child brush teeth at home?
		34. Does your child go to bed with a bottle or sippy cup? If yes, what is in the sippy cup? (Staff: provide some education about sitting sugars and tooth decay)
		35. Has your child visited the dentist?

Nutritional Information

Yes	No	Please answer the following:
		36. Is your child receiving services through WIC?
		37. Does your family receive benefits through the SNAP program?
		38. Do you have questions about feeding your child? If yes, Please explain:
		39. Do you have concerns about what your child eats? How many meals _____ and snacks _____ are offered? Please explain:
		40. Do you share meals together as a family? If no, where does your child eat in the home? _____
		41. Does your child drink from a cup?
		42. Does your child drink from a baby bottle?
		43. Do you have any concerns about your child's growth? Please explain:
		44. Do you have any concerns about your child's weight? Please explain:
		45. Does your child take a prescribed iron supplement? Why? How often? Please explain:
		46. Does your child currently use any nutritional supplements (Pediasure, ensure, multivitamins, herbs, etc.)? If yes, which ones, how often, and for what reason:
		47. Does your child eat any nonfood items? (Example: crayons, marbles, paper, etc.). Please list: _____
		48. How would you describe your child's appetite?
		49. Does your child need assistance with feeding self?

Food Allergies, Intolerances, and Preferences

Yes	No	Please answer the following:
		50. Has a medical provider ever told you that your child has a food allergy or intolerance? If yes, please explain: Does your child have an Epi-Pen? **Is this a life-threatening food allergy?***

Child's Name:		
		51. Are there foods that your child cannot eat for cultural/religious reasons? If yes, please list:
If your child has a food allergy or intolerance that has been diagnosed by a doctor, we will ask for documentation from your medical provider that includes a list of foods that can be substituted.		
****Child Health Plan Required/Potentially life-threatening condition***		

List Health and Nutritional Education Resources Shared with Parents

☐ Lead Information

☐ Nutritional Information

☐ Fluoride Information

☐ Other (please list):
(i.e. tobacco cessation, helmet, car seat, safety, other)

Signatures – First Year

Parent:	Date
Staff who reviewed with Parent	Date reviewed with parent
Interpreter (if applicable)	Date:

Signatures – Second Year

Parent:	Date
Staff who reviewed with Parent	Date reviewed with parent
Interpreter (if applicable)	Date:

COMMUNITY CHILD CARE CENTER

Head Start/EHS/ECEAP/Child Care

Introducing My Family and Me

Child's formal name: _____ Age: _____

Name my child likes to be called: _____

Race/Ethnicity/Family Structure and traditions that are important to our family:

_____

_____

My child lives with these adults:

_____

_____

My child lives with _____ other children. Their names and ages are:

_____

_____

My child is close to:

____Mom/Mama ____Aunt/Tia _____ Others/Ostros (please explain): _____

____Dad/Papa ____Uncle/Tio _____

____Grandfather/Abuelo ____Step Mom/Madrastra _____

____Grandmother/Abuelita ____Step Dad/Padrastro _____

We speak the following languages in our family: _____

_____

Has your child been in any of the following settings?

____Preschool ____In home childcare setting ____Never been in care

____Child Care ____Watched by family/friend

Please describe your child's personality:

_____

_____

What activities does your child really enjoy?

_____

_____

Does your child have any fears or phobias we should know about or has your child experienced any traumatic events?

_____

_____

How do you think your child will respond to new things they might experience in the classroom setting?

What helps your child respond to new social settings or new challenges?

What do you think might be challenging for your child?

As their guardian what is the most important thing you would want me, their teacher, to know about your child?

What skills do you want your child to develop and work on while in the classroom?

Additional Comments: