

**Bright Champs Academy Inc. REGISTRATION FORM**

Child's Full Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Child's home address: \_\_\_\_\_ City: \_\_\_\_\_ State: WA Zip: \_\_\_\_\_

Optional: My child is Native American: YES NO (This OPTIONAL question was requested by social service resources.)

Office use only: Is the child CPS? YES or NO

**Custodial Parent/Guardian Information**

"THE PERSON LISTED BELOW ON THE LEFT WILL BE THE FIRST AND MAIN CONTACT PERSON AS STATED IN THE PARENT HANDBOOK."

Child's parent/guardian name: Relationship to child: Address: <hr/> Does the child live with this person? <b>Yes or No</b> Place of employment: Work #: (        ) Home# : (        ) Cell #: (        ) Email: <hr/> <p align="center"><b>This person may pick up child without prior notification: YES or NO</b></p> <p align="center"><b>This person may visit child at any time without prior notification: YES or NO</b></p>	Child's parent/guardian name: Relationship to child: Address: <hr/> Does the child live with this person? <b>Yes or No</b> Place of employment: Work #: (        ) Home# : (        ) Cell #: (        ) Email: <hr/> <p align="center"><b>This person may pick up child without prior notification: YES or NO</b></p> <p align="center"><b>This person may visit child at any time without prior notification: YES or NO</b></p>
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**Required Medical Information**

Physician's Name & Full Address:

\_\_\_\_\_  
Phone #: \_\_\_\_\_ Date last seen by physician: \_\_\_\_\_

Does your child have any birthmarks or distinctive marks? If so, please list it here: \_\_\_\_\_

Dentist's Name & Full Address (or a preferred dentist):

\_\_\_\_\_  
Phone #: \_\_\_\_\_ Date last seen by a dentist: \_\_\_\_\_

**PARENT'S ALTERNATIVE PERSON NOTIFICATION REQUEST FORM**

Children sometimes become ill or fall down or get bumps or bruises at home, at school, and at child care. Our standard procedure is to notify you of minor illnesses or "ouches" by a written "ouch report" that will be available to you at the time you pick up your child. We will call you in case of illness or "ouch" that is not as minor. If this is necessary, our usual procedure is to call you during the hours your child is in care with us. For some parents, the above system may not be acceptable since some job situations discourage phone calls to parents at work.

If you do not wish to get phone calls regarding your child's health while your child is in our care, you can specify an alternate contact person. If there isn't a specified person, we will contact you.

OPTION 1: Do not call me during the hours my child is in your care. I designate this person to receive notification about my child's health while my child is in your care: \_\_\_\_\_ (Note: This person's information must be in your child's file as a designated pick-up person.)

Parent signature: \_\_\_\_\_ Date: \_\_\_\_\_

OPTION 2: Only call me during the hours my child is in your care if you believe my child needs to be picked up right away and taken to a medical professional. In all other situations, I will receive the child care's center's report when I pick up my child.

Parent signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_**

# BCA, Emergency and Pick-Up Contacts

Child's Name: \_\_\_\_\_

**Note:** Persons between the ages of 16-18 will not be allowed to pick up a registered child unless there is written consent in the file from the custodial parent. Persons under the age of 16 will not be allowed to pick up your child.

We cannot legally stop biological and/or custodial parents/guardians from picking up their child without a court order or other legal appropriate documentation.

<b><u>FIRST AND LAST NAME</u></b>	<b><u>RELATIONSHIP TO CHILD</u></b>	<b><u>FULL Address &amp; Phone #</u></b> (Both are required for a person to be listed here. If no phone # or address, the person will be removed by our management.)	MAY WE CONTACT THIS PERSON TO PICK UP YOUR CHILD IN AN *EMERGENCY ?	DOES THIS PERSON HAVE YOUR PERMISSION TO PICK UP YOUR CHILD AT ANY TIME WITHOUT PRIOR NOTICE FROM YOU?	DOES THIS PERSON HAVE YOUR PERMISSION TO VISIT YOUR CHILD AT ANY TIME WITHOUT PRIOR NOTICE FROM YOU?	IF ADDING INFO, THEN DATE AND INITIAL
		<u>Address:</u>  <u>Phone #:</u>	Yes or No	Yes or No	Yes or No	
		<u>Address:</u>  <u>Phone #:</u>	Yes or No	Yes or No	Yes or No	
		<u>Address:</u>  <u>Phone #:</u>	Yes or No	Yes or No	Yes or No	
		<u>Address:</u>  <u>Phone #:</u>	Yes or No	Yes or No	Yes or No	
		<u>Address:</u>  <u>Phone #:</u>	Yes or No	Yes or No	Yes or No	
		<u>Address:</u>  <u>Phone #:</u>	Yes or No	Yes or No	Yes or No	
		<u>Address:</u>  <u>Phone #:</u>	Yes or No	Yes or No	Yes or No	
		<u>Address:</u>  <u>Phone #:</u>	Yes or No	Yes or No	Yes or No	

\*"Emergency" is determined by our management. For example: natural disaster, sudden child illness/injury, etc. Emergency contacts may be called to pick up your child if parents/legal guardians are unable to be reached.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## BCA, Emergency/Disaster Information, Medical Consent, & Treatment of Minor Children

Child's Full Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Because we must have plans made in case of disasters (such as earthquakes) and potential childcare center evacuation, we are asking parents/guardians to provide our center with information as to who has permission to pick up your child from our centers. **We may be unable to make calls to parents; so this information from you will determine whom we can release your child to.** Telephones cannot be assumed to be a reliable means of communication during an emergency. Listen to radio channels such as KOMO or KIRO AM for the broadcast emergency information for our area. We will do our best to put an instruction or information message on our message machine at for BCA 845-1018. In the event of a center evacuation we will relocate to the Firgrove Elementary gymnasium, 841-8733. In the event of an emergency and/or evacuation, this form will be used to determine who may pick up your child. The only people who will be allowed to pick up your child are those listed below (please include yourself and spouse if applicable.)

FIRST AND LAST NAME	RELATIONSHIP TO CHILD	FULL ADDRESS	PHONE #	ALTERNATE #

The City of Tacoma's Emergency Management Department recommends that in your family plan you have an out-of-area contact person. If we are unable to reach you or you are unable to reach us, we will try to contact the person below to give them any information needed. (Please be aware that our 1<sup>st</sup> priority is the safety of your children. In the event of a major emergency or disaster, we may be unable to reach you or your contact immediately.)

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Physician's Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Full Address: \_\_\_\_\_

In the event of an emergency that could delay your child's pick-up from child care for an undetermined length of time, please list any health/medical conditions, allergies, or special needs we should be aware of:

\_\_\_\_\_

\_\_\_\_\_

*(You are required to provide an alternative food if there are food items on our menus that your child is allergic to)*

If your child is on medication, it is your responsibility to make sure the center has an adequate supply on hand with a correct prescription label) and logged in at the center. Please list your child's regular medications below:

Medication \_\_\_\_\_ Reason \_\_\_\_\_ Dosage \_\_\_\_\_ Time \_\_\_\_\_

"I UNDERSTAND THAT I AM RESPONSIBLE FOR MAKING THE ABOVE ARRANGEMENTS AND KEEPING MY CHILD'S CENTER NOTIFIED OF ANY CHANGES."

"I hereby give permission for my child to be given emergency treatment including, but not limited to, first aid and/or CPR by a qualified staff member at Bright Champs Academy, or Puyallup Summer Day Camp.

"I further authorize Bright Champs Academy, or Puyallup Summer Day Camp to obtain medical treatment, medical procedures, surgery, and/or hospital care for my child when Bright Champs Academy, or Puyallup Summer Day Camp deems it needed or advisable to safeguard my child's health whether or not I can be contacted. I waive my right of informed consent to such treatment."

"I also give permission for my child to be transported by ambulance or car to an emergency center for treatment when deemed necessary by Bright Champs Academy, or Puyallup Summer Day Camp, or emergency medical personnel."

"I give permission for my child to be transported in Bright Champs Academy's vehicles, Puyallup Summer Day camp for the purposes of school transportation, field trips, emergencies, Puyallup Summer Day Camp, and between any of the following: Bright Champs Academy, and Puyallup Summer Day Camp."

"I authorize Bright Champs Academy, or Puyallup Summer Day Camp to transport my child and/or release all of my child's information and paperwork needed by one or more of these organizations to enable it or them to transport my child.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(updated 11/2022)

# BCA, Individual Health Care Plan

**This form must be completed and signed by a health care provider IF there are allergies, health/medical conditions, special needs, or medications. If nothing below applies, then a health care provider signature is not required** (please write N/A below if nothing applies, then the parent will sign the bottom.) *Plan must be updated annually or when there is a change in the child's special need. Please note this page must be approved by the center director prior to enrollment for new children and prior to continued care for a currently enrolled child that is making a change and/or adding new items to this form.*

Child's Full Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Parent's/Guardian's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Primary Health Care Provider: \_\_\_\_\_ Phone #: \_\_\_\_\_

Specialist (If applicable): \_\_\_\_\_ Phone #: \_\_\_\_\_

## **CHILD'S SPECIAL NEEDS, DISABILITIES, ALLERGIES, HEALTH/MEDICAL CONDITIONS, OR MEDICATIONS:**

Diagnosis, if known:
Known symptoms and triggers:
Describe activity, behavioral, or environmental modifications that are needed for the child:
Allergies (other than food allergy):

## **MEDICATIONS (Medication Authorization Form must also be completed for each medication.)**

List medication to be given at scheduled times, and how medication is to be given.
List medication to be given during an emergency, and how medication is to be given.
Describe symptoms that would trigger emergency medication.

## **EMERGENCY RESPONSE PLAN**

List the steps and procedures the early learning provider should perform during an emergency related to the child's special need, disability, allergy, medical or health condition, or medication.
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## **SUGGESTED TRAINING FOR STAFF**

List suggested special skills training/education for the early learning program staff.
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Please attach supporting documentation to this Individual Care Plan, including any existing individual educational plan (IEP), individual health plan (IHP), 504 plan, or individualized family service plan (IFSP). WAC 110-300-0300 requires an early learning provider to have supporting documentation of the child's special needs provided by the child's licensed or certified physician or physician's assistant, mental health professional, educational professional, social worker with a bachelor's degree or higher with a specialization in the individual child's needs, or registered nurse or advanced registered nurse practitioner.

## **SIGNATURES**

_____	_____
Health Care Provider Signature	Date
_____	_____
Parent or Guardian Signature (I also give permission for a visiting health professional to provide services to my child at the early learning program, if applicable)	Date
_____	_____
Early Learning Provider Signature	Date

# BCA, Individual Care Plan for Food Allergy and/or Special Dietary Requirements

**This form must be completed and signed by a health care provider IF there are food allergies and/or special dietary requirements. If nothing below applies, then a health care provider signature is not required** (please write N/A below if nothing applies, then the parent will sign the bottom.) *Plan must be updated annually or when there is a change in the child's special need. Please note this page must be approved by the center director prior to enrollment for new children and prior to continued care for a currently enrolled child that is making a change and/or adding new items to this form.*

Child's Full Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Food the child must NOT consume (List each food separately)	Appropriate substitute food(s)

Describe allergic reactions and symptoms associated with this child's particular allergies:

Describe the treatment plan for the early learning provider to follow in response to child's allergic reaction (include names of medication, dosage amount, and directions for how to administer medication):

Other special dietary requirements due to a health condition:

\_\_\_\_\_  
Health Care Provider Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Early Learning Provider Signature

\_\_\_\_\_  
Date