Infant Center - Preschool - Kindergarten - After School Care
A ministry of Crosswind Community Church
41337 10th Street West Palmdale, CA 93551 (661) 272-0681
adventurelandav@gmail.com

Enrollment Packet

- ❑ Emergency/Contact Form
- ❑ Emergency/Medical Release Form
- ❑ Tuition Agreement
- ❑ Physician's Report (Must be completed within 30 days from your child's start date. On day 31, your child will not be allowed back to Adventureland and his/her spot will not be held unless paid for.)
- ❑ Parent's Rights
- ❑ Personal Rights
- ❑ Pre-Admission Health History
- ❑ Copy of Immunization Record
- ❑ Copy of Parent's Driver's License
- ❑ Copy of Parent's Social Security Card
- ❑ Parent Handbook Statement
- ❑ Allergy Notification/Dietary Restriction Form
- ❑ Diaper Cream/Ointment Authorization Form (if needed)
- ❑ Needs & Service Plan (Infant or Toddler)

Along with the completed enrollment packet, you will need to pay a $100 Registration Fee. Then, wait for a confirmation call from the office verifying the registration packet is complete and has been accepted. This process can take up to 72 hours. Please plan for the waiting period when calculating your child's first day. You can always turn in your paperwork early and we will hold your spot for up to two weeks. Your child will not be enrolled until all the above forms are turned in with the $100 Registration Fee. This Registration Fee is non-refundable. If you have and questions, please contact the school office by phone or email.

Adventureland

Emergency / Contact Form

Child's Name _____ Age _____ Date of Birth _____ [ ] Male [ ] Female

Home Address _____ City & Zip _____ Phone _____

Mother's Name _____ Place of Business _____

Business Address _____ City & Zip _____

Best Contact # _____ Next Contact # _____ Cell # _____

e-mail _____

Father's Name _____ Place of Business _____

Business Address _____ City & Zip _____

Best Contact # _____ Next Contact # _____ Cell # _____

e-mail _____

Who has legal custody of the above stated child? [ ] Mother [ ] Father [ ] Both [ ] Other _____

Do you have legal court custody papers? [ ] Yes [ ] No (If yes, please submit a copy with your enrollment packet)

Please list persons authorized to pick up your child (also considered emergency contacts).
These people will be contacted if the parents are not able to be reached at any time.

Name _____ Relationship _____ Contact # _____

Name _____ Relationship _____ Contact # _____

Name _____ Relationship _____ Contact # _____

Name _____ Relationship _____ Contact # _____

ALL authorized persons must have picture identification with them when picking up.

Does your child have any allergies or food restriction? _____

Is there any important information we should know about your child? _____

Special instructions or information regarding contacting parents _____

_____ _____ _____

Signature Date School Year

Revised on 4/11/2024

Adventureland

Emergency / Medical Release Form

Child's Name _____ Age _____ Birthdate _____
Mother / Guardian _____ Contact #s _____
Father / Guardian _____ Contact #s _____
Alternate Contact _____ Contact #s _____

As the Parent, Agency Representative, or Legal Guardian, I hereby give consent to **Adventureland** to provide all emergency medical or dental care prescribed by a duly licensed Physician (MD), Osteopath (DO) or Dentist (DDS) for the above stated child. This care may be given under whatever conditions are necessary to preserve the life, limb or well being of my dependent.

In case of an emergency I prefer my child to be transported to _____ by the local emergency unit for treatment if they deem it necessary.

It is understood that in some medical situations the staff will need to contact the local emergency resource before consulting the parent, child's physician, and/or the adult acting on the parents behalf.

I understand that payment for the emergency medical treatment will be the responsibility of the parent or legal guardian.

Medications and other significant medical information _____
_____

Medical Information

Physician _____ **Address** _____
Phone _____ **Medical Plan & Number** _____

Dentist _____ **Address** _____
Phone _____ **Medical Plan & Number** _____

If physician cannot be reached, what action should be taken?
[ ] Call emergency hospital [ ] Other Explain: _____

_____
Parent / Representative Signature **Date**

Adventureland

Tuition Agreement

Child's name_____ Start date _____

Person Enrolling Child _____ [] Mother [] Father [] Legal Guardian
Please fill out the following information about you, as the person responsible for the above stated student.
Full legal name _____DOB_____
Address _____
Phone _____ Alternate number _____
Please provide a copy of your Driver's License and Social Security Card.

Please choose the program that will work best for you.

Infant / Toddler Center Weekly Tuition Rates		Preschool Not Potty Trained Weekly Tuition Rates		Preschool 2-4 year olds Weekly Tuition Rates		Kindergarten Weekly Tuition Rates	
[ ] 2 Half Days	$ 96	[ ] 2 Half Days	$ 75	[ ] 2 Half Days	$ 71	[ ] Academic Only 8:30 - 12:30	
[ ] 3 Half Days	$125	[ ] 3 Half Days	$112	[ ] 3 Half Days	$ 107		$149/ week
[ ] 4 Half Days	$150	[ ] 4 Half Days	$136	[ ] 4 Half Days	$131		
[ ] 5 Half Days	$170	[ ] 5 Half Days	$156	[ ] 5 Half Days	$149		
[ ] 2 Full Days	$128	[ ] 2 Full Days	$125	[ ] 2 Full Days	$120	[ ] Academic and Before & After School Care 6:00 am - 6:00 pm	
[ ] 3 Full Days	$170	[ ] 3 Full Days	$163	[ ] 3 Full Days	$155		$210/week
[ ] 4 Full Days	$205	[ ] 4 Full Days	$189	[ ] 4 Full Days	$181		
[ ] 5 Full Days	$250	[ ] 5 Full Days	$220	[ ] 5 Full Days	$210		

Rates effective July 1, 2024

The total Tuition Fee I will be paying weekly will be _____
My child's Attendance Schedule will be (Please list approximate drop off and pick up time):

M _____ T _____ W _____ Th _____ F_____

Please initial the following. By initiating, you are recognizing and agreeing to abide by our policies and procedures. This is not a complete list. Please see the Parent Handbook for more information.

_____*All payments are due weekly before the child attends. If your child is absent, you must call before 12:00 noon to notify the office.*
_____*A late fee will be charged if tuition is not received by Monday at 12:00 noon. (Even if your child is not scheduled to attend on Monday)*
_____*There will be no reduction in tuition for holidays, illness or other time missed (Absence)*
_____*Children are allowed 2 tuition-free "vacation" weeks per school year (Sept –Aug.)*
_____*If you are 2 weeks behind in paying your tuition, your child will be immediately dismissed until your account is made current.*
_____*Full Day students, school hours are from 6:00 am to 6:00 pm. We charge a fee of $5 for any portion of the 1st 5 minutes and $1 a minute after 6:05pm. This is to be paid in cash to the teacher caring for your child at time of pick up.*
_____*Half day students, hours are 8:30 am – 12:30 pm. Must not be drop off before 8:30 am and must be picked up by 12:30 pm. We charge a fee of $5 for any portion of the 1st 5 minutes and $1 a minute after 12:35pm. This is to be paid in cash to the teacher caring for your child at time of pick up.*

I understand that this is an agreement between me, parent/guardian, and Adventureland. By signing this I am accepting financial responsibility for all tuition and charges that may accrue.

_____ _____
Parent/Guardian Signature Date Director Signature Date

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

PHYSICIAN'S REPORT—CHILD CARE CENTERS
(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

_____ (NAME OF CHILD), born _____ (BIRTH DATE) is being studied for readiness to enter

Adventureland (NAME OF CHILD CARE CENTER/SCHOOL). This Child Care Center/School provides a program which extends from 6 : 00 a.m./p.m. to 6:30 a.m./p.m., 5 days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

_____ (SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE) _____ (TODAY'S DATE)

PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware:

Hearing: Allergies: medicine:

Vision: Insect stings:

Developmental: Food:

Language/Speech: Asthma:

Dental:

Other (Include behavioral concerns):

Comments/Explanations:

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
HIB MENINGITIS (REQUIRED FOR CHILD CARE ONLY) (HAEMOPHILUS B)	/ /	/ /	/ /	/ /	
HEPATITIS B	/ /	/ /	/ /		
VARICELLA (CHICKENPOX)	/ /	/ /			

SCREENING OF TB RISK FACTORS (listing on reverse side)

☐ Risk factors not present; TB skin test not required.

☐ Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).
___ Communicable TB disease not present.

I have ☐ have not ☐ reviewed the above information with the parent/guardian.

Physician: _____
Address: _____
Telephone: _____

Date of Physical Exam: _____
Date This Form Completed: _____
Signature _____

☑ Physician ☑ Physician's Assistant ☑ Nurse Practitioner

RISK FACTORS FOR TB IN CHILDREN:

* Have a family member or contacts with a history of confirmed or suspected TB.
* Are in foreign-born families and from high-prevalence countries (Asia, Africa, Central and South America).
* Live in out-of-home placements.
* Have, or are suspected to have, HIV infection.
* Live with an adult with HIV seropositivity.
* Live with an adult who has been incarcerated in the last five years.
* Live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes.
* Have abnormalities on chest X-ray suggestive of TB.
* Have clinical evidence of TB.

Consult with your local health department's TB control program on any aspects of TB prevention and treatment.

FAMILY CHILD CARE HOME
NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the family child care home without advance notice whenever children are in care.
2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.
3. Review, at the family child care home, reports of licensing visits and substantiated complaints against the licensee made during the last three years.
4. Complain to the licensing office and inspect the family child care home without discrimination or retaliation against you or your child.
5. Be notified and receive, from the licensee, a written notice that lists the name of any person not allowed in the family child care home while children are present. ***(NOTE: This notice is only required when the Department has, in writing, excluded someone from the family child care home on or after January 1, 2001).***
6. Request in writing that a parent not be allowed to visit your child or take your child from the family child care home, provided you have shown a certified copy of a court order.
7. Receive from the licensee the name, address and telephone number of the local licensing office.

   Licensing Office Name: Palmdale Child Care

   Licensing Office Address: 39115 Trade Center Dr. Ste. 201, Palmdale CA 93551

   Licensing Office Telephone #: 661-202-3786
8. Be informed by the licensee, upon request, of the name and type of association to the family child care home for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.
9. Receive, from the licensee, the Caregiver Background Check Process form.
10. Be informed, by the licensee, that the facility has or does not have liability insurance (or a bond) that covers injury to clients due to the negligence of the licensee or employees of the facility.

NOTE: CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE FAMILY CHILD CARE HOME TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.

For the Department of Justice "Registered Sex Offender"database, go to www.meganslaw.ca.gov

LIC 995A (8/08) (Detach Here - Give Upper Portion to Parents))

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS
(Parent/Authorized Representative Signature Required)

I, the parent/authorized representative of _____, have received a copy of the "FAMILY CHILD CARE HOME NOTIFICATION OF PARENTS' RIGHTS", the CAREGIVER BACKGROUND CHECK PROCESS and the FAMILY CHILD CARE CONSUMER AWARENESS INFORMATION form from the licensee. Adventureland Preschool / Crosswind Community
Name of Family Child Care Home

Signature (Parent/Authorized Representative) _____ Date _____

NOTE: This Acknowledgement must be kept in child's file and a copy of the Notification given to the parent/authorized representative.

For the Department of Justice "Registered Sex Offender"database, go to www.meganslaw.ca.gov

PERSONAL RIGHTS

Child Care Centers

Personal Rights, See Section 101223 for waiver conditions applicable to Child Care Centers.

(a) Child Care Centers. Each child receiving services from a Child Care Center shall have rights which include, but are not limited to, the following:

(1) To be accorded dignity in his/her personal relationships with staff and other persons.

(2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.

(3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with daily living functions, including eating, sleeping, or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.

(4) To be informed, and to have his/her authorized representative, if any, informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency and of information regarding confidentiality.

(5) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis. In Child Care Centers, decisions concerning attendance at religious services or visits from spiritual advisors shall be made by the parent(s), or guardian(s) of the child.

(6) Not to be locked in any room, building, or facility premises by day or night.

(7) Not to be placed in any restraining device, except a supportive restraint approved in advance by the licensing agency.

THE REPRESENTATIVE/PARENT/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

Palmdale Child Care

NAME

Community Care Licensing Division

ADDRESS

39115 Trade Center Dr. Ste 201

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
Palmdale, CA	93551	661-202-3786

DETACH HERE

TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE: **PLACE IN CHILD'S FILE**

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

ACKNOWLEDGMENT: I/We have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22, at the time of admission to:

(PRINT THE NAME OF THE FACILITY)	(PRINT THE ADDRESS OF THE FACILITY)
Adventureland Preschool / Crosswind Community	41337 10th St. West, Palmdale, CA 93551

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)	(DATE)

STATE OF CALIFORNIA–HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICE
COMMUNITY CARE LICENSIN

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S/FATHER'S DOMESTIC PARTNER'S NAME		DOES FATHER/FATHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
MOTHER'S/MOTHER'S DOMESTIC PARTNER'S NAME		DOES MOTHER/MOTHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
S /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?		DATE OF LAST PHYSICAL/MEDICAL EXAMINATION

DEVELOPMENTAL HISTORY (*For infants and preschool-age children only)

WALKED AT* MONTHS	BEGAN TALKING AT* MONTHS	TOILET TRAINING STARTED AT* MONTHS

PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

	DATES		DATES		DATES
☐ Chicken Pox		☐ Diabetes		☐ Poliomyelitis	
☐ Asthma		☐ Epilepsy		☐ Ten-Day Measles (Rubeola)	
☐ Rheumatic Fever		☐ Whooping cough		☐ Three-Day Measles (Rubella)	
☐ Hay Fever		☐ Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? ☐ YES ☐ NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF

DAILY ROUTINES (*For infants and preschool-age children only)

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*

DIET PATTERN: (What does child usually eat for these meals?)

BREAKFAST

LUNCH

DINNER

WHAT ARE USUAL EATING HOURS?
BREAKFAST _____
LUNCH _____
DINNER

ANY FOOD DISLIKES?

ANY EATING PROBLEMS?

IS CHILD TOILET TRAINED?* ☐ YES ☐ NO	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?* ☐ YES ☐ NO	WHAT IS USUAL TIME?*

WORD USED FOR "BOWEL MOVEMENT"*

WORD USED FOR URINATION*

PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE? ☐ YES ☐ NO	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)? ☐ YES ☐ NO	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
DOES CHILD USE ANY SPECIAL DEVICE(S): ☐ YES ☐ NO	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? ☐ YES ☐ NO	IF YES, WHAT KIND:

PARENT'S EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENTS, BROTHERS, SISTERS AND OTHER CHILDREN?

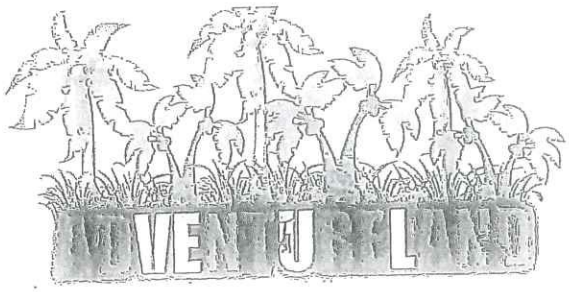
HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT'S SIGNATURE	DATE



PARENT HANDBOOK AGREEMENT

I acknowledge that I may view a copy of the Adventureland Parent Handbook online at crosswindchurch.com.
(Hard copy available upon request)

I understand and agree that it is my responsibility to read and familiarize myself with all the information in this handbook.

By signing below, I am agreeing to all policies, tuitions and fees stated in this handbook.

_____
Child's Name

_____ _____
Parent / Guardian Signature Date

Consent for Pictures	Consent for Observations
I have no objection to my child being included in pictures regarding school activities. I understand that these pictures will be used for school projects, bulletin boards, on our parent communication app, etc. We will not use your child's pictures for the purpose of advertisement without parental consent.	I have no objection to my child being included in observations, and/or reports that might be done for the purposes of interpreting the Adventureland program, licensing reports and educational training. No names will be used in any reports or observations without prior written permission.
Parent/Guardian Signature Date	Parent/Guardian Signature Date

September 5, 2022

Allergy Notification
Dietary Restriction Form

Child's Name _____ Date _____

Below is a list of most foods that your child may come in contact with on a regular basis. Please circle the foods that your child is not able to eat while at our center. Indicate what type of reaction your child would have if ingested. (Anaphylaxis, severe diarrhea, hives, etc.) Also, if your child is allergic to or has any dietary restriction to any of the snacks and/or meals that we service, please provide a subsitute snack/meal. We don't want the kids to go without eating. Thank you

American Cheese
Animal Crackers
Apple Juice
Apples
Applesauce
Bread
Cantalope
Carrots
Cheese & Cheese Crackers
Chicken Nuggets
Corn
Corn Dogs
Fish Sticks
Froot Loops
Frosted Flakes
Fruit Cocktail
Fruit Filled Cereal Bars
Gold Fish
Graham Crackers
Granola Bars
Grape Jelly
Green Beans
Ground Beef
Ham
Honey Nut Cheerios
Honeydew
Hot Dog Buns
Hot Dogs
Jell-O
Ketchup
Lettuce
Mac n' Cheese
Mandarin Oranges
Margarine
Mayonnaise
Milk - 1%
Milk - Whole
Mustard
Nilla Wafers
Pasta
Peaches
Peanut Butter
Pears
Pineapples
Pizza
Pretzels
Pudding
Ranch Dressing
Rice Cakes
Ritz Crackers
Shredded Cheese
Strawberries
String Cheese
Terra Chips
Tortillas
Trail Mix
Tuna
Turkey
Watermelon
Yogurt

Other: _____

Comments: _____

Adventureland Preschool
Diaper Cream/Ointment Authorization Form

For over the counter only, if prescription cream/ointment is needed - please fill out Medication Form.

Child's Name:	Dare of Birth:
Name of Cream/Ointment:	
Start Date:	End Dater: (up to 12 months after start date)
Apply topically: ☐ When rash is present ☐ With every diaper change ☐ Other:	Amount to be applied:
Special Instructions:	

For diaper rash prevention or treatment. Will be stored at room temperature. Staff will indicate when cream/ointment was applied on daily sheet, ClassTag a note home or in person.

Parent/Guardian Signature Date

Infant Needs & Service Plan

Child's Name _____ **DOB** _____

Nicknames you want us to use for your infant _____
Does your infant have any special needs? _____
If yes, please explain _____
_____
From physician's exams and your observations is your infant developing at a normal rate?
[ ] Yes [ ] No
Do you have any concerns regarding your infant? [ ] Yes [ ] No
If yes, please explain _____
Does your infant drink formula or breast milk? [ ] Formula [ ] Breast Milk
If formula, please list brand and type _____
How many ounces is your infant drinking in one sitting? _____
How often does your infant need to be fed? _____
Please list any special instructions regarding feeding your infant a bottle_____
_____
Does your infant eat any food? [ ] Yes [ ] No
If yes, please list _____
What is the consistency of food you would like us to feed your infant?_____
_____
Does your infant have any food likes/dislikes? [ ] Yes [ ] No
If yes, please list _____
Does your infant have any food allergies? [ ] Yes [ ] No
If yes, please list _____
Does your infant feed themselves finger foods? [ ] Yes [ ] No
Does your infant use a spoon? [ ] Yes [ ] No
Are you planning on introducing any new foods within the next three months? [ ]Yes [ ] No
If yes, please list when and what foods _____
Have you introduced your infant to a cup? [ ] Yes [ ] No
If yes, does your infant use a cup at all times? [ ] Yes [ ] No
If no, please list when you would like us to have them use a cup _____
If you have not introduced your infant to a cup, are you planning on introducing it during the next three months? [ ] Yes [ ] No
If yes, please list when _____
Please list the sleeping schedule of your infant (including naps) _____
_____
Does your infant have a special comfort soother? [ ] Pacifier [ ] Blanket [ ] Other
If Other, please list item(s) _____
Please list any special instructions you would like us to know regarding the care of your infant _____

This form is to be updated when your child is 3 months, 6 months, 9 months, 12 months, or as often as needed. It is very important to inform us anytime the information on this sheet changes so we can update our records and provide your child with the best care.

_____ _____

Parents Signature **Date** **Director's Signature** **Date**

Toddler Needs & Service Plan

Child's Name _____ DOB _____

Nicknames _____

Does your toddler have any special needs? YES NO
If yes, please explain _____

From physician's exams and your observations, is your toddler developing at a normal rate? YES NO If yes, please explain _____
_____

Do you have any concerns regarding your toddler? YES NO
If yes, please explain _____

What type of milk does your toddler drink? _____
Please list specific brand and/or type _____

Does your toddler have any food allergies or sensitivities? YES NO
If yes, please list _____
_____

Please list any special instructions you would like us to know regarding the care or feeding of your toddler. _____
_____

This form is to be updated when your child is 12 months, 18 months, or as often as needed. It is very important to inform us anytime the information on this sheet changes so we can update our records and provide your child with the best care.

Parents Signature _____ Date _____

Director's Signature _____ Date _____