CHILD APPLICATION

Iron Range Tykes Learning Center
8520 Park Ridge Dr, Mt Iron MN 55768
P: 218-248-6881 F: 218-288-5896

Child's name_____ **Childs D.O.B**_____

Billing/Home Address:_____

Main Phone: _____ **Guardian:** _____

Child's hours at center:
Schedules are due to the teacher of each room by Wed @ 3PM the week prior

Monday	Tuesday	Wednesday	Thursday	Friday

The package I am choosing is: (currently for infants: we only offer 5 Day pkg and Drop In)

____ 5 DAY PKG ____ 4 DAY PKG ____ 3 DAY PKG ____ DROP IN/DAY RATE

(Note: you are not locked in to this package/ will review details at tour appointment)

Schedule notes_____

School Age Transportation:

☐ My child will be using transportation by this school:_____ Bus # _____

☐ Suburban ☐ Bus Pick Up Time:_____ Drop Off Time: _____

☐ I have informed the school of my child's transportation to/from IRT

Fee: County _____ Private _____ **Desired Start Date:** _____

-OFFICE USE ONLY-

Tour date: _____ Actual start date: _____ Registration Paid: _____

Notes: _____

_____

Please bring (labeled with first & last name) these items
Are needed before your child/children attend:
(Note: these items will be left at the center)

□ **Infant:** Formula or breast milk, bottle, pacifier, diapers, wipes, diaper rash cream, 2 sets of *extra clothes, and written or typed daily routine schedule w/ a description of the child's eating, sleeping, toileting, and communication habits, and effective methods for comforting.

□ **Toddler:** Diapers/pull ups, wipes, diaper rash cream, 1 set of *extra clothes, and nap blanket.

□ **Preschooler:** Diapers/pull ups, wipes, 1 set of *extra clothes and nap blanket.

□ **School Ager**: 1 set of *extra clothes.

*Shirt, pants/shorts, underwear and socks in a labeled gallon baggie

□ **Immunization records** on our form. If parent objects to immunizations, a signed notarized statement of parental objection on the specified MN state form

□ **Health Care Summary form** must be completed by child's medical

□ **Any additional optional forms at bottom of application**

- Special Diet Statement completed by Physician
- Individual Child Care Program Plan (ICCPP)
- Consent for swaddling an infant
- Physician directive for alternative infant sleep position
- Infant rolling before six months parent statement

□ **Registration Fee** $40 per child w/ a maximum of $80 a family

Parent Checklist Acknowledgement

I understand without this application fully completed, necessary forms, and registration fee, my child will not be enrolled to start care with Iron Range Tykes. All this information is kept on file in each child's room along with documentation of conferences/reports that are conducted twice a year.

Signature_____ Date: _____

INFORMATION FORM FOR (Childs name): _____

Mother's Name_____

Address: _____

Home Phone_____ Cell Phone_____ Email _____

Mother's Work_____ Work Phone_____

Instructions on best way to reach you_____

Father's Name_____

Address: _____

Home Phone_____ Cell Phone_____ Email _____

Father's Work_____ Work Phone_____

Instructions on best way to reach you_____

Siblings:_____

(Please note if they live at home with child. If applicable use reverse side to describe special family dynamics, custody, interactions with step/half siblings, etc.)

Previous group or child care experiences_____

Allergies _____

Specific allergy triggers_____

Avoidance techniques_____

Allergy Symptoms_____

Procedures for allergic reaction_____

Dietary restrictions _____

Daily Medications_____

Other Significant Information_____

Physician: _____ Phone_____

Address_____

Dental Source_____Phone_____

Address_____

To insure prompt medical attention in case of an emergency, please list:

Insurance Policy Number (s)_____ _____

Medical assistance Number(s)_____

If possible, for emergency treatment, I would prefer my child be taken to: _____

Authorized/Emergency Pick Up People

Please list a minimum of 3 authorized people to pick up your child from the center. These authorized below will be contacted to take responsibility of your child if you cannot be reached or in case of emergency. Some instances are if your child becomes ill or if there is an emergency. Please list people who can be reached during the day and live within 1 hour of the centers location. Do not list yourself or other legal guardians.

Name_____ Address_____

Relationship: _____Phone_____ Work Phone_____

Name_____ Address_____

Relationship: _____Phone_____ Work Phone_____

Name_____ Address_____

Relationship: _____Phone_____ Work Phone_____

Name_____ Address_____

Relationship: _____Phone_____ Work Phone_____

Name_____ Address_____

Relationship: _____Phone_____ Work Phone_____

Name_____ Address_____

Relationship: _____Phone_____ Work Phone_____

Child's Developmental History:

1. Does your child know any other children at this center? _____
2. Do you feel your child will adjust easily to the center? _____
3. How well does your child get along with other children? _____
4. Left handed _____ Right handed _____ Unknown _____
5. Favorite play activity? _____
6. Favorite toy/toys? _____
7. Does your child have a pet? _____
8. Does your child take a nap? _____ How long? _____
9. Is your child hungry at meal times? _____ Food dislikes? _____
10. Usual characteristic behavior: (circle all that apply) Calm Excited Whiny Easily angered Cries often Happy Cheerful Stubborn Easily scared Cooperative Quiet Active Independent Fights often Wants own way Temper tantrums Easy going Clingy Sad Helpful Shy Friendly
11. What type of behavior do you find most difficult to deal with?
    _____
12. Types of home discipline by mother _____
    by father _____
13. Fears (history and how child shows fear) _____
14. What frustrates or upsets your child? _____
15. Primary language spoken in the home? _____
16. Does your child have any difficulties speaking? _____
17. Special words child uses to describe his/her needs? _____
18. What word is used for urination? _____ Bowl movements? _____
19. Has child had experience with: Clay_____ Scissors_____ Blocks_____ Coloring_____
    Easel painting_____ Water play _____ Story hour _____
20. Does your child have any needs requiring special attention?
    _____
21. Does either parent have any special requests?
    _____
22. Does either parent have any skills to offer?
    _____

Activity Consent

I hereby grant permission for my child:

- to use all the playground and gym equipment.
- to participate in all the activities of the center.
- to be included in evaluations and pictures connected with the centers program
- to be included in approved university educational resources.
- to participate in walking trips, field trips, public activities or other activities sponsored by the center.
- to have sunscreen and/or insect repellent applied, in which I will provide, to their class room teacher when needed and sign a form each year

Parent/Guardian Signature: _____Date_____

Emergency Consent

I give Iron Range Tykes Learning Center permission to make whatever emergency measures as judged necessary for the care and protection of my child while under supervision.
In case of a medical emergency, I understand that my child will be transported to an appropriate medical facility by local emergency unit for treatment, if the local emergency resource deems it necessary.
It is understood that in some medical situations, the staff will need to contact the local emergency resource before the parent, child's physician and/or other adult acting on the parent's behalf.
In case of emergency involving my child, I authorize Iron Range Tykes Learning Center to use Essentia Health Hospital of Virginia for emergency medical treatment, if I or my own source of medical care listed prior, cannot be reached.
I hereby grant permission for the Directors or acting Director to take whatever steps that may be necessary to obtain emergency medical care for my child if warranted. These steps may include, but are not limited to the following:

1. **Attempt to contact parent or guardian**
2. **Attempt to contact child's physician**
3. **Attempt to contact the parent through any of the persons listed on the emergency medical form.**
4. **If #1-3 are unsuccessful, A) call another physician, B) call the paramedics, C) have the child taken to the emergency hospital.**

I understand that any expenses incurred under #4 above will be accepted by the child's family.

Mother/Guardian Signature _____Date_____

Father/Guardian Signature _____Date_____

Enrollment Agreement

I (we) have fully read and understood the Parent Handbook that is located on the Iron Range Tykes Website. I (we) agree to abide by the policies and procedures as stated in the Handbook. I (we) also understand that changes may be made by the Owner to the Parent Handbook regarding policy changes at any time. I (we) understand that I (we) will be notified prior to any changes.

I understand that IRT does not offer any absent, vacation, or sick time. Schedules and changes are due by the week prior. After that, you are charged accordingly.

I understand that my only access into the center is with my key fob. If I lose or break my key fob a $50 charge will be due before my child can return.

I understand that if this application, Health Care provider forms, and registration fee are not fully completed or submitted I will not be enrolled and a spot will not be held for me.

Parent/Guardian #1Signature:_____Date_____

Parent/Guardian #2 Signature:_____Date_____

IRON RANGE TYKES HEALTH CARE SUMMARY

Fax # 218-288-5896

MUST BE COMPLETED BY HEALTH CARE SOURCE
MUST BE ON FILE BEFORE CHILD CAN START CARE

Date of Enrollment: _____

NAME OF CHILD _____ Birth Date _____

ADDRESS _____ Telephone _____

PARENT(S) OR GUARDIAN_____

Date of last physical examination _____How long have you been seeing this child? _____

How frequently do you see this child when he/she is not ill? _____

Does this child have any allergies (including allergies to medications)? _____

Is a modified diet necessary? _____

Is any condition present that might result in an emergency? _____

_____

What is the status of the child's. . . Vision _____

Hearing _____

Speech _____

Please list below the important health problems:

Important Health Problems	Followed by (Medical source)	Requires Special Attention at Center

_____

_____

_____

_____

Other information helpful to the child care program _____

_____

Physician Signature: _____ Date _____

Address:_____Phone:_____

Immunization

Name _____ Birthdate _____

Enter the dates for each vaccine your child has received to date. Specify the month, day, and year of each dose such as 01/01/2010.

Immunizations required for child care, early childhood programs, and school.

Vaccine	Birth to 6 months				12-24 months		At Kindergarten	At 7th grade	At 12
Hepatitis B									
Diphtheria, Tetanus, Pertussis (DTaP, DT, Td)									
Haemophilus influenzae type b (Hib)									
Pneumococcal (PCV)									
Polio									
Measles, Mumps, Rubella (MMR)									
Chickenpox (varicella)									
Hepatitis A									
Tetanus, Diphtheria, Pertussis (Tdap)									
Meningococcal (MCV4)									

Minnesota law requires children enrolled in child care, early childhood education, or school to be immunized against certain diseases, unless the child is medically or non-medically exempt.

Instructions for parent or guardian:

1. Fill out the dates in chronological order even if your child received a vaccine outside of the age/grade category that the box is in. Depending on the age of your child, they may not have received all vaccines; some boxes will be blank.
   - If you have a copy of your child's immunization history, you can attach a copy of it instead of completing the front of this form.
   - Your doctor or clinic can provide a copy of your child's immunization history. If you are missing or need information about your child's immunization history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-3980 or 800-657-3970.
2. Sign or get the signatures needed for the back of this form.
   - Document medical and/or non-medical exemptions in section 1.
   - Verify history of chickenpox (varicella) disease in section 2.
   - Provide consent to share immunization information (optional) in section 3.

Instructions: Complete section 1 to document a medical or non-medical exemption, section 2 to verify history of varicella disease

1. Document a medical and/or non-medical exemption (A and/or B).
Place an X in the box to indicate a medical or non-medical exemption. If there are exemptions to more than one vaccine, mark each vaccine with an X.

Vaccine	Medical Exemption	Non-Medical Exemption
Diphtheria, Tetanus, Pertussis		
Polio		
Measles, Mumps, Rubella		
Haemophilus influenzae type b		
Chickenpox (varicella)		
Pneumococcal		
Hepatitis A		
Hepatitis B		
Meningococcal		

A. Medical exemption: By my signature below, I confirm that this child should not receive the vaccines marked with an X in the table for medical reasons (contraindications) or because there is laboratory confirmation that they are already immune.

Signature (of health care practitioner*): _____ Date: _____

2. History of chickenpox (varicella) disease. This child had chickenpox in the month and year

My signature below means that I confirm that this child does not need chickenpox vaccine because:

☐ I am a health care practitioner and this child was previously diagnosed with chickenpox or the parent provided a description that indicates this child had chickenpox in the past.

☐ I am the parent or guardian and this child had chickenpox on or before September 1, 2010.

Signature: _____Date: _____

*Health care practitioner is defined as a licensed physician, nurse practitioner, or physician assistant.

B. Non-medical exemption: A child is not required to have an immunization that is against their parent or guardian's beliefs. However, choosing not to vaccinate may put the health or life of your child or others they come in contact with at risk. Unvaccinated children who are exposed to a vaccine-preventable disease may be required to stay home from child care, school, and other activities in order to protect them and others.

By my signature, I confirm that this child will not receive the vaccines marked with an X in the table because of my beliefs. I am aware that my child may be required to stay home from child care, school, and other activities if exposed.

Signature: _____ Date: _____

(of parent or guardian in presence of notary)

Non-medical exemptions must also be signed and stamped by a notary: This document was acknowledged before me

on _____ (date) Notary Stamp

by _____

(name of parent or guardian)

Notary Signature: _____

Individual Child Care Program Plan (ICCPP)
Special Needs/Diagnosis/ Food Allergy/ Animal Allergy/Prevention and Response

Child's Name: _____ Date of Birth: ____/____/____

Parent/Guardian #1 Name: _____

Home#_____ Work#_____ Cell#_____

Parent/Guardian #2 Name: _____

Home#_____ Work#_____ Cell#_____

Primary Health Provider's Name: _____ Phone: _____

Primary Health Provider's Clinic: _____ Phone: _____

Other Specialist's Name/Title (If Applicable): _____Phone: _____

Specialist's Clinic: _____Phone:_____

If child has an allergy, please fill out the following so staff can be trained and informed.

Description of the allergy:_____

Specific Triggers:_____

Procedure for responding to allergic reaction: _____

Avoidance Techniques: _____ _____

Symptoms of an allergic reaction:_____ _____

Current Medicines/Doses: _____

If child has special needs, care or diagnosis you would like staff to be aware of please fill out this section. Ex- Speech delay, hearing impairment, ect.

Diagnosis(es): _____

Areas of developmental delay/concern: _____

Parent/Guardian #1Signature:_____ Date_____

Parent/Guardian #2 Signature:_____Date_____

OPTIONAL FORM FOR CHILD WITH SPECIAL NEEDS

ICCPP for Dietary Preference Request Form

This form can be used to request dietary preferences that are not related to a medical need or disability. Sponsors of Child and Adult Care Food Program (CACFP) are encouraged but not required to accommodate reasonable dietary requests for a participant who does not have a medical need or disability. In order to claim these meals or snacks for reimbursement, the accommodation made must still meet CACFP meal pattern requirements. If the participant has a medical need that restricts their diet they should complete the Special Diet Statement.

Participant Information

Participant's Name: Last/First/Middle Initial

Today's Date

Name of Center: Iron Range Tykes

Date of Birth

Parent/Guardian Name:

Home Phone:

Work Phone:

Participant Status (check one):

☐ Participant does not have a medical need or disability, but is requesting a dietary accommodation based on a dietary preference.

☐ Participant does not have a medical need or disability, but is requesting that they be served an approved fluid milk substitute in place of cow's milk.

Dietary Accommodations

1. State the preferred dietary accommodation:

List specific foods to be omitted and substituted. Attach a sheet with additional instructions as needed.

Foods to be Omitted	Food to be Substituted

Signature

Signature:

Date:

Printed Name:

Relationship to participant:

Phone Number:

Daily Infant Intake Form

Name: _____ **Birthdate:** _____

_____ Breast milk Formula Both

How many ounces:_____How often:_____

Directions for using both: _____

_____

_____

My baby can have -- Start Date:

Iron fortified infant cereal Oatmeal Cereal Rice Cereal Multigrain Cereal

_____

Baby Food- Fruit -- Start Date:

_____ Apples _____ Bananas _____ Prunes _____ Pineapple

_____ Pears _____ Peaches _____ Mixed Berry _____ Blueberry

_____ Strawberry Other:

_____.

Baby Food- Vegetables -- Start Date:

_____ Peas _____Carrots _____ Squash _____ Green Beans

_____ Mixed Vegetable Garden Vegetable Sweet Potato

Other:_____

_____

My baby is on table foods -- Start Date: _____Yes _____ No _____ Some

Which foods?

_____

_____

Dietary Concerns or Foods to Avoid:

_____

_____

Tell us about naptime:

Soothing Techniques:

Other notes:

Notes for Parents

1. **At the age of 1 only the 360 cup is used -- no bottles**
2. **Utensils are used/provided**
3. **Between 12 and 13 months they transition to whole milk**
4. **At the age of 1 they are solely on table food provided by IRT**

Minnesota Department of **Human Services**

Physician Directive for Alternative Infant Sleep Position

The American Academy of Pediatrics (AAP)*, National Institute of Child Health and Human Development (NICHD) and the Minnesota Sudden Infant Death (SID) Center at Children's Hospitals and Clinics of Minnesota recommend back sleeping for babies to reduce the risk of sudden unexpected infant deaths (SUID) due to sudden infant death syndrome, suffocation, and other sleep related causes. The 2011 AAP recommendation further states that an alternative sleep position be considered only for the rare exception of infants for whom the risk of death when sleeping on the back is greater than the risk of SUID when sleeping on the stomach. **Babies sleep safest on their backs.**

Minnesota law requires that licensed providers place infants to sleep in a crib, directly on a firm mattress. The provider must place the infant on his/her back for sleep unless the provider has a signed directive from a physician for an alternate sleep position for the infant. Car seats, swings, couches, the floor on a blanket, etc. are **not** acceptable as an alternative sleep position.

This form is the approved format to direct an alternative sleep position and must remain on file at the licensed location.

In addition, Minnesota law requires licensed providers to use a fitted crib sheet that fits tightly on the mattress and overlaps the underside of the mattress so it cannot be dislodged by pulling on the corner of the sheet with reasonable effort. Nothing may be placed in crib with the infant except the infant's pacifier. These requirements apply to license holders serving infants up to one year of age. Licensed providers may only use cribs that meet requirements specified in statute and must inspect cribs monthly to assure they are safe.

I understand that back sleeping is recommended and is safest for babies. I am directing an alternative position for this infant for the reason(s) stated below. By signing this form I am acknowledging that I am directing only an alternative sleep position and that the infant must always be placed in an approved crib to sleep.

NAME OF CHILD	DATE OF BIRTH

_____ Place this infant on his/her STOMACH for sleep periods (***not recommended); OR***

_____ Place this infant on his/her SIDE for sleep periods (***not recommended)*** Medical Reason(s) for

alternate sleep position:_____Expected duration of need for alternate sleep position:_____

When infant will be re-evaluated re: need for alternative sleep position:_____

P PRINTED NAME AND SIGNATURE OF PHYSICIAN	DATE

Parent Signature:_____ Date:_____

Provider Signature:_____ Date:_____

Minnesota Department of **Human Services**

Parental Consent for Swaddling an Infant

Placing a swaddled infant down to sleep in a licensed setting is ***not*** recommended for an infant of any age* and is prohibited for any infant who has begun to roll over independently.

However, with written consent of a parent or guardian, a license holder may place the infant who has NOT YET BEGUN to ROLL OVER ON ITS OWN down to sleep in a crib, on their back, in a onepiece sleeper equipped with an attached system that fastens securely ONLY across the upper torso, with no constriction of the hips or legs, to create a swaddle.

Any other type of swaddle, including with a blanket, is prohibited.

Prior to any use of swaddling for sleep by a licensed provider, the license holder must obtain informed written consent for the use of swaddling from the parent or guardian of the infant. The parent or guardian must demonstrate to the provider how to safely place baby in the swaddle so it is not too tight or too loose.

I _____, the parent/guardian, of _____DOB_____
(infant)

give written consent to Iron Range Tykes Learning Center to place my infant to sleep in a crib, on their back, in a one-piece sleeper equipped with an attached system ("wings") that fastens securely ONLY across the upper torso to create a swaddle.

_____I verify that my infant has NOT yet begun to roll over.
_____I verify provider will only use the one-piece sleeper to swaddle my infant
_____I verify that the provider has a one-piece sleeper with attached "wings" OR
_____I verify that I have provided the one-piece sleeper with attached "wings"
_____I verify I demonstrated to the provider how to place baby in the swaddle.
_____I verify I will immediately notify provider when infant has begun to roll over.

Signature of Parent _____ Date _____

Signature of Provider_____ Date _____

At the time that the parent or provider observes that this infant has begun to roll over, this parental consent is no longer valid. Document below when baby has begun to roll over.

Date: _____ Provider Initials: _____Parent Initials: _____

OPTIONAL FORM FOR INFANTS UNDER 6 MONTHS