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 @ 6PM 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 ____ SCHOOL YEAR WEEKLY PKG

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

Schedule notes_____

School 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 IRT

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

-OFFICE USE ONLY-

Tour date: _____ Actual start date: _____ Registration Paid: ___ County Approved: ___

Notes: _____

_____

REQUIRED PAGE
FILL OUT ONLY THIS PAGE IF EXPECTING

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 able 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.

Name_____ Address_____

Phone_____ Work Phone_____

Name_____ Address_____

Phone_____ Work Phone_____

Name_____ Address_____

Phone_____ Work Phone_____

Name_____ Address_____

Phone_____ Work Phone_____

Name_____ Address_____

Phone_____ Work Phone_____

Name_____ Address_____

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 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_____

HEALTH CARE SUMMARY

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 Form

Name _____

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
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 guardian)

Notary Signature: _____ Stamp:

Child Enrollment Form
Child and Adult Care Food Program

Dear Parents,

Your child care center participates in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). This child care center receives federal cash assistance to serve healthy meals to your children. Good nutrition today means a stronger tomorrow! Meals served here must meet nutrition requirements established by USDA's CACFP. In order to participate, your center has agreed to follow USDA guidelines. In an effort to assess that these requirements are being met, USDA's CACFP requires centers to annually collect the enrollment information listed below. Please complete the form and return it to your child care center.

Name of Child Care Center: Iron Range Tykes Learning Center Beginning Date of Care: _____

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

Schedule	Monday	Tuesday	Wednesday	Thursday	Friday		
Enter the normal hours your child is in care*							
Check the meals your child normally receives while in care:	☐ Breakfast ☐ Lunch ☐ PM Snack	☐ Breakfast ☐ Lunch ☐ PM Snack	☐ Breakfast ☐ Lunch ☐ PM Snack	☐ Breakfast ☐ Lunch ☐ PM Snack	☐ Breakfast ☐ Lunch ☐ PM Snack		

Beginning Date of Care: _____

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

Schedule	Monday	Tuesday	Wednesday	Thursday	Friday		
Enter the normal hours your child is in care*							
Check the meals your child normally receives while in care:	☐ Breakfast ☐ Lunch ☐ PM Snack	☐ Breakfast ☐ Lunch ☐ PM Snack	☐ Breakfast ☐ Lunch ☐ PM Snack	☐ Breakfast ☐ Lunch ☐ PM Snack	☐ Breakfast ☐ Lunch ☐ PM Snack		

Parent's Signature: _____ Parent's Name (please print)_____ Date: _____

Home Phone: _____ Work Phone: _____ Mailing Address: _____

City: _____State: _____MN_____ Zip: _____

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) Mail:
U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) Fax: (202) 690-7442; or

(3) Email: program.intake@usda.gov

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Information needs to be updated annually. If the above information is still accurate initial and date below.

Initial						
Date:						

Child and Adult Care Food Program – Child Care Centers Household Income Statement – JULY 2018

Step 1 List all infants, children and students through grade 12 in the household, even if they are not related. If more space is needed, attach another sheet.

Child's First Name	MI	Child's Last Name	Birthdate	If yes, fill in one or more circles for each child. ***Ethnicity and Race are Optional***							
				Enrolled at this center?	**Foster Child?**	***Ethnicity***	***Race – One or more may be selected***				
						Hispanic / Latino?	***American Indian or Alaskan Native?***	***Asian?***	***Black or African American?***	***Native Hawaiian or other Pacific Islander?***	***White?***
				○	○	○	○	○	○	○	○
				○	○	○	○	○	○	○	○
				○	○	○	○	○	○	○	○
				○	○	○	○	○	○	○	○
				○	○	○	○	○	○	○	○

Step 2 Do any household members currently participate in ☐ **SNAP?** ☐ **MFIP?** ☐ **FDPIR? If yes, case number :_____**
Check the program box and then go to Step 4. Medical Assistance and WIC do not qualify for Step 2. **If no,** go to Step 3.

Step 3 Report income for all household members. Skip this step if you answered yes to Step 2 or if all participants are foster children. **A.** Include the total income a child may earn or receive here. Child Income: **: _____**

○ Wkly ○ Bi-Wkly ○ 2x Month ○ Monthly

B.Adult Income. Include self & record total income below. List all adult household members even if don't receive income

Adults - Full Name	**Gross Pay from Work** Do not write in an hourly wage					**Farm or Self-Employment**	**Public Assistance, Child Support, Alimony**					**All Other Incomes**				
List full name of each household member living with you and shares income and expenses. Include any college students temporarily away.	Gross pay before taxes (not take-home pay)	Weekly	Bi-Weekly	2 X Month	Monthly	Net Income after business expenses. State if annual or monthly.	Payments received	Weekly	Bi-Weekly	2 X Month	Monthly	Pension, retirement, disability, unemployment, Veterans benefits, etc.	Weekly	Bi-Weekly	2 X Month	Monthly
	$	○	○	○	○	$	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	$	○	○	○	○	$	○	○	○	○

C. Last 4 digits of signer's Social Security Number (SSN) or no SSN (required): X X X–X X–☐☐☐☐ or ☐ don't have one

Step 4 I certify (promise) that all information on this application is true and correct and all household members and incomes are reported. I understand that this information is given in connection with receipt of federal funds and that officials may verify (check) the information. I understand that if I purposely give false information, I may be prosecuted under applicable federal and state laws.

Signature (required): _____Printed Name: _____Date: _____

Sponsor Use Only—Do Not Write Below

Approved: ☐ A—Foster ☐ A—Case Number ☐ A—Income ☐ B—Income ☐ C—Over Income

Total Household Members: _____ Total Income: $_____ per _____

Effective Dates: From _____ through _____

Sponsor Signature _____Date _____

Farmer or Self-Employed

Income is your *net* income (after deducting business expenses) from farm or self-employment during the year, which is generally shown on Schedule C or F from the federal tax return. A loss from farm or self-employment must be listed as zero income and does not reduce other household income for the purpose of completing this form.

Seasonal Worker

Income is your expected *average gross income* before deductions (*not* take-home pay) from seasonal work during the year. List your *average gross income* from seasonal work per month or other frequency.

Privacy Act Statement / How Information Is Used

The Richard B. Russell National School Lunch Act requires the information on this form. You do not have to give this information but if you do not, we cannot approve your child for free or reduced-price school meals. You must include the last four digits of the Social Security number of the adult household member who signs the application. The last four digits of the Social Security number are not required when you apply on behalf of a foster child, or you provide a Minnesota Family Investment Program (MFIP), Supplemental Nutrition Assistance Program (SNAP) or Food Distribution Program on Indian Reservation (FDPIR) assistance number, or you indicate that the adult household member signing the application does not have a Social Security number.

Only authorized officials will have access to the information you provide on this form. We will use your information to determine if your child qualifies for free or reduced-price meals, and for administration and enforcement of the program. We may share your information with other 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. We require written consent from you before sharing information for other purposes.

While listing your children's race and ethnicity is voluntary, CACFP uses the percentages of participants in each racial and ethnic category to make sure CACFP is operated in a nondiscriminatory manner and in compliance with federal and civil rights laws. The information is not required and will not affect approval of benefits.

Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the *USDA Program Discrimination Complaint Form* (AD-3027) found online at: *http://www.ascr.usda.gov/complaint_filing_cust.html*, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) Mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) Fax: (202) 690-7442; or (3) Email: *program.intake@usda.gov*.

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Office Use Only: Verification (Pricing Program Only)

Date Verification Sent: _____ Response Due: _____ 2nd Notice: _____ Result: ○ No Change ○ A to B ○ A to C ○ B to A ○ B to C

Reason for change: ○ Income ○ Case number not verified ○ Foster not verified ○ Refused cooperation ○ Other: _____

Signature of verifying official: _____Date: _____

Individual Child Care Program Plan (ICCPP)

If child has special needs or care please fill out the following form so staff can be trained and informed. Examples would be preferring almond milk vs cows milk or delayed speech.

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: _____

Name of Primary Health Provider's Clinic: _____ Phone: _____

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

Name of Specialist's Clinic: _____Phone:_____

Diagnosis(es): _____

_____

Areas of Developmental Delay/Concerns: _____

_____

_____

Current Medicines/Doses: _____

_____

My child has no special care or needs required but I want the staff and facility aware of the above information.

Parent/Guardian #1Signature:_____Date_____

Parent/Guardian #2 Signature:_____Date_____

Individual Child Care Program Plan (ICCPP)
Allergy Prevention and Response

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

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:_____

Description of the allergy: _____

_____

Specific Triggers:_____

_____

Avoidance Techniques:_____

_____

Symptoms of an allergic reaction: _____

_____

Current Medicines/Doses: _____

_____

Parent/Guardian #1Signature:_____Date_____

Parent/Guardian #2 Signature:_____Date_____

Daily Infant Intake Form

Name: _____ **Date:** _____

_____ Breast milk How many ounces:_____ How often: _____

_____ Formula

My baby can have:

_____Iron fortified infant cereal _____ Puffs

Baby Food- Fruit:

_____ Apples _____ Bananas _____ Prunes _____ Pineapple

_____ Pears _____ Peaches _____ Mixed Berry _____ Blueberry

_____ Strawberry Other:_____

Baby Food- Vegetables:

_____ Peas _____ Carrots _____ Squash _____ Green Beans

_____ Mixed Vegetable _____Garden Vegetable _____ Sweet Potato

Other:_____

My baby is on table foods: _____Yes _____ No _____ Some

Which foods?_____

_____

Tell us about naptime: _____

_____

Other notes: _____

_____

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:_____

PRINTED NAME AND SIGNATURE OF PHYSICIAN	DATE

Parent Signature:_____ Date:_____

Provider Signature:_____ Date:_____

ALTERNATIVE INFANT SLEEP POSITION PARENT & PROVIDER INFO FORM

One of the easiest ways to lower a baby's risk of Sudden Unexpected Infant Death (SUID) due to sudden infant death syndrome (SIDS), suffocation, and other sleep related causes is to put the baby on the back to sleep for naps and at night. Health care providers used to think that babies should sleep on their stomachs, but research now shows that babies are less likely to die of SUID when they sleep on their backs. Since the recommendation to place a baby on their back for sleep began, the SIDS rate in the United States has dropped by more than 50 percent. Placing babies on their back to sleep is the best way to reduce the risk of SUID. **The following are recommended for Safe Sleep for Your Baby:**

1. Always place a baby on his or her back to sleep, for naps and at night. The back sleep position is the safest position for all babies and every sleep time counts.
2. A baby should be put to sleep in a safety-approved crib on a firm mattress covered by a fitted sheet appropriate to the mattress size.
3. Keep soft objects, toys, loose bedding, pillows, blankets, quilts, sheepskins and crib bumpers out of the baby's sleep area. The only item that should be placed in the crib with the baby is a pacifier. **Please note: In licensed programs, the only item allowed in a crib with an infant is a pacifier.**

- As the parent providing this physician signed form I am acknowledging that I have read the above information regarding the AAP and NICHD recommendations for sleeping babies safely, Minnesota's requirements for licensed providers, and recommendations from **Safe Sleep for Your Baby**. The Safe Sleep for Your Baby Brochure may be viewed at:
  https://www.nichd.nih.gov/publications/pubs/Documents/STS_SafeSleepForYourBaby_General_2013.pdf
- As the parent providing this physician signed form I am acknowledging that I am aware that placing a baby on her/his back for sleep has been recommended by health experts to be the safest way to place a baby for sleep.
- As the parent providing this physician signed form I am acknowledging that I am aware that since the recommendation to place babies on their back for sleep began, the SIDS rate in the United States has dropped by more than 50 percent.
- As the parent providing this physician signed form I am acknowledging that I am aware that placing a

baby on the stomach or side, places the baby at greater risk for dying from Sudden Unexpected Infant Death (SUID).

- As the parent providing this physician signed form I am acknowledging that I am aware that Minnesota Statute, Section 245A.1435, requires licensed providers to position an infant on the back for sleep unless the provider has a signed directive from a physician for an alternate sleep position.

Parent 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 <u>only</u> 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: _____

Special Diet Statement

Institutions or organizations who sponsor and operate a federally funded Child Nutrition Program must make reasonable substitutions to meals and/or snacks on a case-by-case basis for participants who are considered to **have a disability that restricts their diet:** School Nutrition Program – 7 CFR 210.10(m), Child and Adult Care Food Program – 7 CFR 226.20 (g), Summer Food Service Program – 7 CFR 225.16(f)(4). According to the ADA Amendments Act, **most physical and mental impairments that substantially limit or affect one or more major life activities or bodily functions will constitute a disability.**

Sponsors are not required to accommodate special dietary requests that do not constitute a disability, including requests related to religious or moral convictions or personal preference. If these requests are accommodated, sponsors must ensure that all USDA meal pattern and nutrient requirements are met.

This form must be completed by a licensed physician, physician assistant, or an advanced practice registered nurse, such as a certified nurse practitioner. Updates to this form are required only when a participant's needs change.

Note to Districts/Schools: Parents/Guardians may provide a written request for lactose-reduced milk without a physician's signature.

Participant Information

Participant's Name: _____ Date of Birth: _____ Today's Date: _____
Last/First/Middle Initial

Name of School/Center/Site Attended: Iron Range Tykes Learning Ctr Date of Birth: _____

Parent/Guardian Name: _____

Home Phone Number: _____ Work Phone Number: _____

Required Information: Dietary Accommodation

State the allergen or food to be avoided: _____

Brief explanation of how exposure to this food affects the participant:_____

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

Foods to be Omitted	Foods to be Substituted

☐ Additional Information Texture Modification: ☐ Pureed ☐ Ground ☐ Bite-Sized Pieces ☐ Other:_____

☐ Tube Feeding Formula Name: _____

Administering Instructions: _____

Oral Feeding: ☐ No ☐ Yes If yes, specify foods: _____

☐ Other Dietary Modification Or Additional Instructions (describe): _____

Signature Licensed physician, physician assistant, or advanced practice registered nurse such as a certified nurse practitioner must sign and retain a copy of this document.

Prescribing Authority Credentials (print): _____Date: _____

Signature: _____Clinic/Hospital: _____

Phone Number: _____Fax Number: _____

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992.

Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW Washington,
D.C. 20250-9410

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov

This institution is an equal opportunity provider.