Child's name ___________________________ DOB ______________

Program ______________________________ Start date ___________

Please submit the following items with your enrollment packet:

- ☐ Deposit _________ & Registration fee ______
- ☐ Financial agreement
- ☐ Enrollment agreement
- ☐ Information form
- ☐ Authorization form
- ☐ Permission form
- ☐ Birth certificate and state form 50548
- ☐ Immunization record
- ☐ health/physical form – signed by doctor
- ☐ Medication form – signed by doctor
- ☐ Food allergies/dietary requests – signed by doctor
- ☐ Safe Transportation of Food
- ☐ Breastmilk Procedure
- ☐ Suggested Feeding Plan

Items discussed with Director (parent initial)

- ☐ Payment policy _____
- ☐ Vacation policy _____
- ☐ Material fee _____
- ☐ Medical issues _____
- ☐ Food allergies _____
- ☐ Medication policy _____
- ☐ Disenrollment policy _____
- ☐ Security Deposit policy _____

Enrollment Packet

Joyful Education

Funshine Children's Center

Since 1983

3535 West 96th Street
Indianapolis, Indiana 46268
Phone: (317) 872-7755
Fax: (317)872-6511

Funshineforkids@sbcglobal.net

www.funshineforkids.com

Bob & Sandy Barnes — Owners

Melissa Lawson, Director

Trisha Mustin, Asst. Director

Dear Funshine Parents,

Welcome to Funshine Children's Center! We are so glad that you have trusted Funshine with the care of your children. The attached packet contains the paperwork that you will need to complete in order to enroll your child. In addition to the necessary paperwork we ask that you bring the following items:

Infants

- Labeled sleep sack
- 2 portable crib sheets
- Feeding bib and sippy cup (for older infants)
- Supply of unopened diapers
- Unopened supply of wipes
- please note the breast milk and formula procedures
- unopened baby food and cereal
- extra clothing and a 16 qt. tub to store clothes, pacifier etc…
- family photo
- diaper rash cream
- medication (renewed annually and must be included on child's medication form)

Toddlers and Twos

- supply of unopened diapers/pull ups
- unopened box of wipes (1 large refill package or 3 Small at the beginning of each month)
- diaper rash cream
- Feeding bib and sippy- cup (1 year)
- sunscreen
- blanket and travel sized pillow (labeled) – crib size sheet (regular size)
- extra clothing to be stored in child's cubby & a small shoe sized tub
- Tennis shoes for outdoor/gym activities
- family photo
- medication (renewed annually and must be included on child's medication form)

Preschoolers

- blanket and travel sized pillow (labeled) – crib size sheet optional
- extra clothing to be stored in child's cubby
- 6 qt plastic container (to store clothing)
- Tennis shoes for outdoor/gym activities
- Family photo
- Sunscreen
- medication (renewed annually and must be included on child's medication form)

Enrollment Agreement

Name of child ____

Please read carefully and circle the appropriate response

Yes	No	I have received, read, understand, and agree to abide by the written Policies set forth in the Parent Handbook. I understand that these policies may be changed and every attempt will be made to give notice of the changes prior to implementation
Yes	No	I understand that in the event of illness or injury to my child, every to contact me will be made. I give permission for First Aid to be administered by trained staff. If, in the opinion of a staff member, the illness or injury needs treatment, I hereby give consent for medical treatment by a qualified doctor selected by the person in charge of the center. Funshine Chidlren's Center are herewith relieved of all liability expressed or implied which may result from such services.
Yes	No	I agree to remain current on my child's weekly tuition. I understand That if the balance on my account becomes excessive, I will be asked to withdraw my child.
Yes	No	I understand that my child is enrolled for a probationary period of Two weeks for the purpose of evaluating the child's aptitude for the Program and the program's appropriateness for the child. If it is Deemed by the staff it is necessary to withdraw the child after this Evaluation period, the material fee will be returned.
Yes	No	I understand that a child may be asked to be withdrawn without Refund at any time if it is determined that child's presence is Detrimental to himself or others.
Yes	No	I understand that if I hire a present employee, or someone who has Been a Funshine employee within six months of hire to work for you You agree to pay Funshine a placement fee of $2,500.

Signature ________________________________ Date __________

Funshine Children's Center

Financial Responsibility

I am enrolling my child ______________________ in the Funshine Children's Center program this ___ day of _______________, 20 ___. I understand that I am registering my child for ____ days per week and that the fee I will paying is $______each week. This fee is due on Friday for the following week. Each payment will be made prior to the child care service rendered by the Funshine staff. There is a $45.00 service charge for all returned checks. After the second NSF check is received, Funshine Children's Center will no longer accept payment by personal check. Subsequent fees must be paid by cash, cashier's check or money order.

The Funshine Children's Center is open Monday through Friday 6:30 a.m. until 6 p.m. A late fee of $20 will be charged for the first five minutes and $2 per minute fee there after whenever a child is picked up late. We are closed on New Year Day, Memorial Day, July 4th, Labor Day, Thanksgiving Day and Christmas Day. I understand that there are no tuition credits for absences for any reason (illness, vacations or holidays).

A non-refundable registration fee of $100 is required when enrolling a child and a material fee of $70 will be due bi-annually for children 1+ (due in the fall and spring). A 4 week security deposit is required for infant enrollment. Half of the security deposit (2 weeks tuition) is refunded when my child turns one year, and the remainder of the security deposit will be refunded when a 2 week written notice of disenrollment is given. I understand that there is a 6 month commitment for enrollment in the infant program, and that the security deposit is nonrefundable if less than 6 month written notice of disenrollment is given. A 2 week security deposit is required for children 1+ and is nonrefundable if less than 2 week written notice of disenrollment.

If you hire one of our present employees, or someone who has been a Funshine employee within six months of hire to work for you, you agree to pay Funshine a placement fee of $2,500.00.

I will be responsible for the payment of the weekly tuition and related fees for my child if there is a change in Funshine Children's Center fee schedule. In the event that my account becomes delinquent and is turned over to a collection agency I agree to pay all late and legal fees resulting from this course of action.

Signature ____ Date _____________

Signature ____ Date _____________

EZ-EFT Authorization Form

I hereby authorize

____

Name of your financial institution

To make our weekly payment on our behalf from the checking account listed below and transfer it to Funshine Inc.

I understand that I am in full control of my payment, and if at any time I decide to make any changes I will notify Funshine Inc. with two weeks written notice.

Client name ____

Address ____

City __________________________________ State _____ Zip ____________________

Signature _______________________________________ Date ___________________

Attach voided check here (or copy)

Information Form

Child's name ______________________________ Date of Birth _______________

Primary contact

Relationship to child ____

Name ___________________________________ Cell phone _______________

Home address _________________________ City __________ State ___ Zip _____

Email address _______________________ Home phone ______________________

Employer _________________________________ Work Phone ______________

Secondary contact

Relationship to child ____

Name ___________________________________ Cell phone _______________

Home address _________________________ City __________ State ___ Zip _____

Email address _______________________ Home phone ______________________

Employer _________________________________ Work Phone ______________

Other than parent, who is authorized to transport your child?

Name ___________________________________ Phone __________________

Relationship to child ____

Name ___________________________________ Phone __________________

Relationship to child ____

Name ___________________________________ Phone __________________

Relationship to child ____

Authorizations

The individuals listed below are authorized to pick up my child, ____________________ or to assume responsibility for my child in case of emergency, accident or illness. If none of the people listed are available, I give my permission to Funshine Children's Center staff to make a plan for the care of my child. It is required that someone other than the parent be listed in case of an emergency.

_______________________ _______________ Signature of Parent/Guardian Date

Please list parent/guardian first

Primary contact	Relationship
Work Phone	Home/Cell Phone
Secondary contact	Relationship
Work Phone	Home/Cell Phone
Name	Relationship
Work Phone	Home/Cell Phone

Release for Emergency Care

If my child is injured while at Funshine, first aid procedures will be followed and I will be notified. In case of life threatening illness or injury, my child will be taken to the nearest emergency medical center. I understand that I will be notified immediately; however in the event that I can't be reached, the Funshine staff shall act on my behalf; medical costs for injuries to children while at school are normally covered by family health insurance in the same way as costs of injuries sustained elsewhere. Funshine does not provide medical or accident coverage on children, nor does it administer any special plan for purchase by parents.

In the event that I cannot be reached or make arrangements for emergency medical attention of the time of illness or accident, I hereby authorize Funshine Children's Center to take my child ____________ to:

Physician ___________________ Address ________________ Phone __________
Dentist ____________________ Address ________________ Phone __________
Hospital ____________________ Address ________________ Phone __________

I hereby give my consent to the physician and/or hospital to administer any necessary treatment to my child. I give consent to transport my child by ambulance if the situation warrants it.

Child's date of birth _____________________ date of last DPT or Tetanus__________
Allergies ____________________________ Chronic conditions _______________
Name of insurance company ____
Policy number ___________ Group number __________ Date of expiration _________

________________________________ _______________________
Signature of parent/guardian Date

________________________________ _______________________
Signature of parent/guardian Date

All about me

To assist in getting to know your child better we ask you to complete the following information:

Child's Name: ______________________ Nickname: _____________________

Child's date of birth: _______________

My child is toilet trained ___ Yes ___ No

My child has ________ brother(s) _________sister(s)

Their names and ages are ____

My child has _____________pet(s), their names are __________________________

Our family lives in a _____ house _____ apartment

My child is adopted ____ Yes ____ No; if yes, at what age and is he/she aware? __________

My child has attended preschool before ____ Yes ____ No

My child prefers to use his/her ____ right hand ____ left hand

My child is on the following medications: ____________________________________

My child has the following allergies: ____

Does your child have any history of vision/hearing/speech problems? __________________

My child is: in diapers in pull-ups fully potty-trained partially potty-trained

My child helps at home by ____

What do you hope to gain from your experience at Funshine? _______________________

____

List any hobbies, talents, or professional experiences that you would be interested in sharing with the children at Funshine

____

____

Over the counter drug medication form

All medications, medical products, cough drops, physician's sample medications and skin care products given or used at a child care center must include the exact name of the medication, dosage to be given, time to be given and reason for use. If used for a fever, the degree of temperature must be stated. A physician's order is valid for one year.

1. ______________________ may have ___________________________
(Name of child) (Name of medication)
______________________ every ________________________ for
(Dosage) (Frequency)
____
(Reason)

_________________ ______________________________________
(Date) (Physician's signature)

2. ______________________ may have ___________________________
(Name of child) (Name of medication)
______________________ every ________________________ for
(Dosage) (Frequency)
____
(Reason)

_________________ ______________________________________
(Date) (Physician's signature)

3. ______________________ may have ___________________________
(Name of child) (Name of medication)
______________________ every ________________________ for
(Dosage) (Frequency)
____
(Reason)

_________________ ______________________________________
(Date) (Physician's signature)

Permission Form

I request that my child _______________________ be allowed to attend any field trips taken by my child's class at Funshine Children's Center. For children 2 ½ and older, this may include nature walks that are located within .25 miles of Funshine property, but does not include travel on roads or sidewalks. I understand that I will be notified in advance of all field trips that involve transportation.

_______________________ ______________________________

(Date) (Parent or Legal Guardian Signature)

Publicity Release

My child _________________________ does / does not have my permission to be photographed for publicity

_______________________ ______________________________

(Date) (Parent or Legal Guardian Signature)

BUREAU OF CHILD CARE
DIVISION OF FAMILY RESOURCES

SAFE TRANSPORTAION OF FOOD RESPONSIBILITY

Food must be brought to the facility in clean, insulated, sanitizable containers, which keeps cold food at 41° F or below and hot food at 135° or above. Containers must be clearly labeled with the child's name and date of preparation.

Upon receiving the food from the parent, the facility shall verify the temperature of the food. When potentially hazardous food temperature is not correct, the facility will not accept the food.

Upon accepting the food, the facility shall maintain correct food temperatures until served.

PARENT AGREEMENT

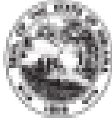
I, ____ (Parent's name) will

provide food for______________________ (Child's name).

I take full responsibility for the safety of my child's food during preparation, storage, and transportation to the facility.

(Parent's Signature):____

(Date):______________________



LICENSED CHILD CARE CENTER / HOME CONSENT

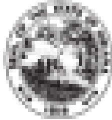
State Form 50548 (R2 / 7-06) / BCC 0080

To: Parents of licensed child care programs in Indiana

Subject: Your child's birth certificate and licensed child care programs

Indiana Code 12-17.2-2-1(8) requires each child care center or child care home to record proof of a child's date of birth before accepting the child for care. A child's date of birth may be proven by the child's original birth certificate or other reliable proof of the child's date of birth, including a duly attested transcript of a birth certificate. Refusing to share this information may result in your child's exclusion from a licensed child care program. Sharing the birth certificate information is NOT optional; signing the below is your decision and does not impact your use of child care facilities.

- Tear here -



LICENSED CHILD CARE CENTER / HOME CONSENT

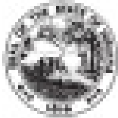
State Form 50548 (R2 / 4-06) / BCC 0080

This portion is to be kept on file at the licensed child care program.

I give my permission for Funshine Children's Center (*name of licensed child care program*) to report the name and date of birth of my child or children to the Division of Family Resources pursuant to IC 12-17.2-2-1.5.

Name of child	Date of birth (month, day, year)
Name of child	Date of birth (month, day, year)
Name of child	Date of birth (month, day, year)
Name of child	Date of birth (month, day, year)

Signature of parent, guardian, or custodian	Date signed (month, day, year)



HEALTH CARE PROGRAM FOR CHILD CARE CENTERS
CHILD CARE CENTER HEALTH RECORD

State Form 49969 (R4 / 2-15)

FSSA - MS02
402 WEST WASHINGTON STREET, RM W361
INDIANAPOLIS, IN 46204

Name of child (last, first)	Date of birth (month, day, year)	Date of admission (month, day, year)
Address (number and street, city, state, and ZIP code)		
Child lives with (relationship)	Name	Telephone number ( )

MEDICAL HISTORY

Communicable Disease	Month / Year	Condition	Explain if present
		Allergies:	
		Handicapping conditions:	
Screenings	**Result / Date (month, day, year)**		
TB Risk / Symptom		Other:	
Developmental Screen			
Lead			

PHYSICAL EXAMINATION

Date of exam (month, day, year)	Age of child
Skin	Heart
Lymphnodes	Lungs
Eyes	Abdomen
Ears	Genitalia
Nasopharynx	Skeleton
Teeth and Mouth	Other:

Note any unusual findings:

Does this child have any health condition that would be hazardous either to the child or to other children in a group setting as a result of participation in normal activities (including sports)?

☐ Yes ☐ No If Yes, what modification of normal activities would be necessary to protect the child and the child's classmates:

Have you prescribed any medications or special routines which should be included in the center's plans for this child's activities? Explain:

☐ Yes ☐ No

(Over)

HISTORY OF IMMUNIZATIONS AND TEST (*indicate month / day / year*)

	1	2	3	4	5
DTaP / DT					
Hib					
IPV (Polio)					
* Influenza (Flu)					
Measles Mumps Rubella (MMR)					
Rotavirus (RGE)					
Varicella (Varivax)					
Pneumococcal (PCV) (Prevnar)					
HEP A					
HBV (HEP B)					

Hib: doses 1–4; MMR: doses 1–2; Rotavirus: doses 1–3; Varicella: doses 1–2; Pneumococcal: doses 1–4; HEP A: doses 1–2; HBV: doses 1–3.

Varicella: or Chicken Pox Disease — Month / year

* Recommended yearly.

Name of physician / nurse practitioner completing form (please print)	Telephone number ( )
Signature of physician / nurse practitioner	

ADDITIONAL NOTES AND INSTRUCTIONS