

# Walnut Hill Early Childhood Center Enrollment Form

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

Start Date: \_\_\_\_\_

Class: \_\_\_\_\_

• **CHILD INFORMATION**

Child's full name \_\_\_\_\_ Nickname \_\_\_\_\_  
D.O.B. \_\_\_\_\_ Current Age \_\_\_\_\_ Gender \_\_\_\_\_ Race \_\_\_\_\_

Hours Child will Attend: Monday through Friday from \_\_\_\_\_ to \_\_\_\_\_

• **PARENT OR GUARDIAN INFORMATION**

**\*Parent 1** \_\_\_\_\_ Home # \_\_\_\_\_ Cell # \_\_\_\_\_

Home Address \_\_\_\_\_

Place of Employment \_\_\_\_\_ business phone # \_\_\_\_\_

Work Address \_\_\_\_\_ Work Hours: \_\_\_\_\_

E-mail or other information about this parent: \_\_\_\_\_

**Parent 2** \_\_\_\_\_ Home # \_\_\_\_\_ Cell # \_\_\_\_\_

Home Address \_\_\_\_\_

Place of Employment \_\_\_\_\_ business phone # \_\_\_\_\_

Work Address \_\_\_\_\_ Work Hours: \_\_\_\_\_

E-mail or other information about this parent: \_\_\_\_\_

**Marital Status?** \_\_\_ M \_\_\_ Si \_\_\_ Se \_\_\_ Di \_\_\_ Wi **Head of House?** \_\_\_ F \_\_\_ M \_\_\_ Two Parent

- **Primary language spoken in home:** \_\_\_\_\_
- **Family History/Custody Arrangements/Changes for child (moving, parent leaving or coming back, etc):**

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- **Please share any Current Custody Concerns your Child's Caregiver Should Know:**

## FAMILY INFORMATION

- Home and Family**

List siblings

Name	Place of Residence	Age of Sibling

List others who reside in the same home as the child:

Person's Name	Relationship to Child	Permanent/Temporary

- Pick-up Information**

- ✓ Your child will be released to the following individuals only. (You do not need to include yourself)
- ✓ In case of emergency, these people may be given access to child's pertinent health information
- ✓ Changes can be made verbally over the telephone or by you in person.

1. Name \_\_\_\_\_ Address \_\_\_\_\_  
Phone \_\_\_\_\_ Relationship \_\_\_\_\_
2. Name \_\_\_\_\_ Address \_\_\_\_\_  
Phone \_\_\_\_\_ Relationship \_\_\_\_\_
3. Name \_\_\_\_\_ Address \_\_\_\_\_  
Phone \_\_\_\_\_ Relationship \_\_\_\_\_
4. Name \_\_\_\_\_ Address \_\_\_\_\_  
Phone \_\_\_\_\_ Relationship \_\_\_\_\_

- If you child becomes ill or injured at the center, who should we call?**

First: \_\_\_\_\_ at this phone #: \_\_\_\_\_

Second: \_\_\_\_\_ at this phone #: \_\_\_\_\_

- Restricted Persons who may not pick up child:** \_\_\_\_\_

- ✓ Walnut Hill cannot prevent a legal parent from picking up child without legal documentation.
- ✓ Always call if you or others picking up cannot arrive before 5:40 p.m. when the center closes

- Please share any special circumstance that could affect your child:**

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**WALNUT HILL EARLY CHILDHOOD CENTER**  
**FAMILY FINANCIAL CONTRACT**

**Parent or Guardian,**

You are entering a Financial Contract with Walnut Hill Early Childhood Center. Your weekly fee is based upon the information you provide pertaining to family size and income. This contract is reviewed every six months while your child is enrolled.

**Child's Name** \_\_\_\_\_ **Start Date:** \_\_\_\_\_

**Person Providing Financial Information** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**Person Responsible to Make Payments:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

<b>Number Persons Living in the Home:</b>	
<b>Income:</b>	<b>Weekly Income Amount:</b>
First Weekly Gross Salary Amount and # of hours	\$
Second Weekly Gross Salary Amount and # work hrs	\$
Social Security (Monthly/ Weekly)	\$
Unemployment (Monthly/ Weekly)	\$
TANF, Foster Care/ other government funds	\$
Child Support (Number of children it supports)	\$
Other:	\$
Total Income:	\$
<b>Weekly Fee Assigned:</b>	\$
Percent of Poverty	%      Median

**Signatures Verify:**

- ✓ The information provided is current, accurate and complete.
- ✓ I will notify Walnut Hill of any changes in my household income or family size.
- ✓ I understand that failure to pay regularly will result in my child being dismissed from the Walnut Hill program.
- ✓ I understand that I can make arrangements with the Family Services Coordinator when my family or I have circumstances that affect my ability to pay.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
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.

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## 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 \_\_\_\_\_ to report the name and date of birth  
*name of licensed child care program*  
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 ( <i>month, day, year</i> )
Name of child	Date of birth ( <i>month, day, year</i> )
Name of child	Date of birth ( <i>month, day, year</i> )
Name of child	Date of birth ( <i>month, day, year</i> )

Signature of parent, guardian, or custodian	Date signed ( <i>month, day, year</i> )
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## MEDICAL INFORMATION

Child's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Age: \_\_\_\_\_

Person(s) Providing Information/Relationship to Child: \_\_\_\_\_

<input type="checkbox"/> Medical Alert <input type="checkbox"/> No Special Conditions
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- Child's Doctor: \_\_\_\_\_  
Doctor's Telephone: \_\_\_\_\_ Address: \_\_\_\_\_
- Child's Dentist: \_\_\_\_\_  
Dentist's Telephone \_\_\_\_\_ Address: \_\_\_\_\_
- Other Specialists: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Address: \_\_\_\_\_
- Allergies: \_\_\_\_\_  
**May we post your child's allergies as a reminder to staff?** ☐ Yes ☐ No
- Any Physical Concerns or Disabilities? \_\_\_\_\_
- Any ongoing Medications? \_\_\_\_\_
- Any Medical Concerns (Seizures, serious illnesses or past hospitalizations)?  
\_\_\_\_\_
- Is your child likely to have frequent:  
☐ Nose bleeds ☐ Diarrhea that does not affect health ☐ Headaches ☐ High fever ☐ Other \_\_\_\_\_
- Has your child received speech services in the past? If yes, then when? \_\_\_\_\_
- Notification of Parents in case of Illness or Injury:
  - ✓ Parents are always called when a child sustains injuries that could require a decision.  
(i.e. a significant bump to the head, a tooth knocked loose, a cut close to the eye etc.)
  - ✓ First aid is administered and children are observed after any accident. A written note is provided to parents regarding any injury – minor or significant. *Please always call with questions or for more details*
  - ✓ Parents are always called when a child has vomited more than once, has ongoing diarrhea or has had an injury requiring more than a simple band aid.

### When do you want the center to call?

☐ Just when necessary for making decisions ☐ After any minor fall or injury requiring a band aid  
☐ Other: \_\_\_\_\_

### Access to Your Child's Health Records

- ✓ State officials
- ✓ Center Director and FSC
- ✓ Who else may have access to your child's health records?  
☐ Child's Classroom Staff ☐ Lead teacher only ☐ Kitchen Staff ☐ Afternoon Staff  
☐ Other: \_\_\_\_\_

## Parent Agreements

To my knowledge, my child is free from any communicable disease. Yes\_\_ No\_\_

My child has been vaccinated according to CDC or AAP. Yes\_\_ No\_\_

My child has religious exemption for vaccinations. Yes\_\_ No\_\_

When my child turns 3 or older, I give Walnut Hill Staff my permission to give acetaminophen to my child. Yes\_\_ No\_\_

I understand Walnut Hill's legal obligation to report any suspected cases of child abuse or neglect to Child Protective Services. Yes\_\_ No\_\_

I have been informed about and have received a copy of Walnut Hill's Curriculum. Yes\_\_ No\_\_

I have been informed about Walnut Hill's Discipline Policy. Yes\_\_ No\_\_

Walnut Hill Staff have my permission to wake my child at the end of the Center's designated sleep times (7:15 a.m. and 2:30 p.m.). Yes\_\_ No\_\_

Walnut Hill Staff have my permission to allow my child to use playground Equipment and other large motor equipment while at Walnut Hill. Yes\_\_ No\_\_

Walnut Hill Staff have my permission to include my child in walking field trips. Yes\_\_ No\_\_

Walnut Hill Staff have my permission to use sunscreen on my child. Yes\_\_ No\_\_

Walnut Hill Staff have my permission to use insect repellent on my child. Yes\_\_ No\_\_

I understand my family's insurance carrier is used if my child is injured or becomes ill. Yes\_\_ No\_\_

I understand the center staff will call 911 if my child has a medical emergency. Yes\_\_ No\_\_

I understand the center staff will use the Heimlich Maneuver or CPR if necessary. Yes\_\_ No\_\_

Walnut Hill Staff has my permission to administer basic first aid if my child sustains minor injuries. Basic first aid includes ice packs, band-aids, hydrogen peroxide, rubbing alcohol, Triple Antibiotic Ointment, water, and cotton balls. Yes\_\_ No\_\_

I understand Walnut Hill staff can only administer medication or medical treatment  
\_\_\_ when my child's physician writes written authorization on the prescription pad or  
\_\_\_ if the medication or treatment includes a current prescription label for my child. Yes\_\_ No\_\_

I give my permission for my child to be photographed by the newspaper or to be included in any television shot. Yes\_\_ No\_\_

I give my permission for my child to be photographed by the center for use on the center's Facebook page and/ or the center's website. Yes\_\_ No\_\_

I give my permission for my child to be included in photos taken by parents during birthday celebrations and other special events. Yes\_\_ No\_\_

**I certify that the information I have provided today is complete and correct to the best of my knowledge.**

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**Parent/Guardian Signature**

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**Date**

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# PHYSICAL FORM FOR CHILD

State Form 49969 (R6 / 01-25)  
FAMILY AND SOCIAL SERVICES ADMINISTRATION  
OFFICE OF EARLY CHILDHOOD AND OUT-OF-SCHOOL LEARNING

FAMILY AND SOCIAL SERVICES  
ADMINISTRATION - MS02  
402 W. Washington St., Room W362  
Indianapolis, IN 46204

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

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

PHYSICAL EXAMINATION	
Date of exam ( <i>month, day, year</i> )	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 ( <i>including sports</i> )?	
<input type="checkbox"/> Yes <input type="checkbox"/> 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:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	

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

This image shows a blank sheet of white paper with horizontal dashed lines, typical of primary-ruled notebook paper. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.





<Insert Provider/Facility Name Here>

## Special Dietary Needs Form

Complete and submit this form to <insert facility name>. The parent/guardian/adult participant will complete part 1 and 2, and the physician or medical authority (physician's assistant, nurse practitioner, or registered dietitian) will complete part 3. Refer to the information below for clarification. Attach a sheet with additional information if necessary. If changes are needed, the parent/guardian/adult participant is required to submit a new form.

### GUIDANCE

#### Disability:

USDA requires substitutions or modifications in CACFP meals for participants whose disabilities restrict their diets. The definition of the term "disability" has broadened and nearly all physical and mental impairments constitute a disability.

Section 504 of the Rehabilitation Act, the Americans with Disabilities Act, and Departmental Regulations at 7 CFR Part 15b define a person with a disability as any person who has a physical or mental impairment which substantially limits one or more "major life activities," has a record of such impairment, or is regarded as having such impairment. (See 29 USC § 705(9)(b); 42 USC § 12101; and 7 CFR 15b.3.) "Major life activities" are broadly defined and include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. "Major life activities" also include the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions. (See 29 USC § 705(9)(b) and 42 USC § 12101.)

A physical or mental impairment does not need to be life threatening to constitute a disability. It is enough that the impairment limits a major life activity. Further, an impairment may be covered as a disability even if medication, or another mitigating measure, may reduce the impact of the impairment.

Forms or medical statements for disabilities must be signed by a licensed physician, physician's assistant, nurse practitioner, or registered dietitian and must identify: the child's medical condition; an explanation of why the disability restricts the child's diet; the major life activity affected by the disability; the food or foods to be omitted from the child's diet, and the food or choice of foods that must be substituted.

#### Special Dietary Needs That Are Not a Medical Condition:

Food service may make food substitutions for reimbursable meals, at their discretion, for individual children who do not have a disability/medical condition, but who have special dietary needs for other reasons such as religious, cultural, or other preferences when such substitutions meet the meal pattern. CACFP participating organizations are encouraged to accommodate reasonable requests, but are not required to do so. For these requests, the form may be signed by a parent/guardian/adult participant.

The form should include: an identification of the special dietary need that restricts the diet; the food or foods to be omitted; and the food or choice of foods to be substituted.

Participants' Name:		Birthdate:     /     /	
Parent/Guardian/Authorized Representative name:			
Home Phone: (     )		Work Phone: (     )	
Address:			
City:	State:	Zip:	

**Special Dietary Need that is not a Medical Condition**

Describe the participant's special dietary need:

Foods to be omitted:

Substitutions:

Please list additional information regarding the diet:

Parent/guardian/adult participant/rep. of adult participant signature

Date

**Disability/Medical Condition**

Describe the patient's medical condition and the major life activities that are affected:

Foods to be omitted:

Substitutions:

Please list additional information regarding the diet (including texture changes such as chopped, ground, pureed, etc.):

Licensed physician, physician's assistant, nurse practitioner, or registered dietitian signature

Date

Printed name and title

Telephone

# Home Language Survey\*

☐ Check here if the child's parents or legal guardians decline to provide information for this survey.

## A. What language do family members use when speaking to the child in the home?

N/A	1	2	3	4	5
Not applicable	only English	mostly English but sometimes home language	both equally	mostly home language but some English	only home language (not English)

## B. What language does the child use when speaking to family members in the home?

(write in home language: \_\_\_\_\_)

N/A	1	2	3	4	5
Not applicable	only English	mostly English but sometimes home language	both equally	mostly home language but some English	only home language (not English)

## C. What language does the child use when speaking to other children in the classroom?

N/A	1	2	3	4	5
Not applicable	only English	mostly English but sometimes home language	both equally	mostly home language but some English	only home language (not English)

## D. What language does the child use when speaking to the teachers?

N/A	1	2	3	4	5
Not applicable	only English	mostly English but sometimes home language	both equally	mostly home language but some English	only home language (not English)

Sum of circled numbers

Number of questions answered

/ =

If this value is 2 or greater, assess the child by using Objectives 37 and 38.

\*These research reports helped guide our thinking in the development of the "Home Language Survey":

Alkins, N. L., Caspe, M. S., Sprachman, S., Lopez, M. L., & Alkins-Burnett, S. M. (June 2008). *Paper Symptom: Development of a language routing protocol for determining bilingual Spanish-English speaking children's language of assessment*. Biennial Head Start Research Conference. Washington, DC.

Puma, M., Bell, S., Cook, R., Held, C., Lopez, M. L., et al. (2005). *Head Start impact study: First year findings*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families.

Gutiérrez-Clellen, V. F., & Kreiter, J. (2003). Understanding child bilingual acquisition using parent and teacher reports. *Applied Psycholinguistics*, 24(2), 267-88.

## *Child Interest Survey*

We are excited to have your child in our classroom this year, and we are looking forward to getting to know them better! Please take a minute to fill out this child interest survey to help us learn more about your child and their interests. We use Creative Curriculum and the interests of your child when we make lesson plans. When children are interested in something, they are more likely to be involved and engaged in the activity. The more engaged they are, the more they will learn!

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

Date: \_\_\_\_\_

Siblings (Name and Age): \_\_\_\_\_

\_\_\_\_\_

Favorite Foods: \_\_\_\_\_

Interests (favorite activities, toys, etc.):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Strengths (things they can do right now):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What is one or two things that you would like your child to learn this year (that is developmentally appropriate for their age)?

1. \_\_\_\_\_

2. \_\_\_\_\_

\_\_\_\_\_

# Parent Interest Survey

Dear Parents,

Walnut Hill believes that you are your child's first and most important teacher! We want to work with you in giving your child the best early education possible. We love for families to be involved and participate in classroom activities. Not only does your child love to have you at school with them, but it also helps raise their self-esteem. It shows them that parents and teachers work together to care for them.

Walnut Hill has an open-door policy. You are invited to visit the classroom ANYTIME, and we encourage you to participate in planned activities. Extended family is also welcome to participate (with your permission).

We understand not all parents will be able to participate during the day so we have a few ideas of some activities that can be done at home as well as some activities that can be done at school. Please mark activities that you are interested in participating in. We look forward to partnering with you and **APPRECIATE** your work as a parent.

Name \_\_\_\_\_

1. \_\_\_\_\_ Read to the class.
2. \_\_\_\_\_ Play a musical instrument for the class.
3. \_\_\_\_\_ Attend special class activities (ex.-Valentines Party, Fall Harvest Celebration, Christmas Party)
4. \_\_\_\_\_ Bring a picture of a pet to share with the class.
5. \_\_\_\_\_ Record yourself reading a book for the class.
6. \_\_\_\_\_ Cook with your family and take pictures to share with the class.
7. \_\_\_\_\_ Bring in clothing, flags, or other items from other countries to share with the class and discuss.
8. \_\_\_\_\_ Take home art projects to do with your child and send it back to share.
9. \_\_\_\_\_ Spend a day at Walnut Hill interacting with children and helping where needed.
10. \_\_\_\_\_ Make games for children to play. (Materials can be provided by the teachers.)
11. \_\_\_\_\_ Preparing, cutting, laminating, or making copies for the class (These things can be done at home as well.)
12. \_\_\_\_\_ Tearing inappropriate adds out of magazines sent to Walnut Hill.
13. \_\_\_\_\_ Make play dough for the classrooms and send to school. (The teachers can give you recipes.)
14. \_\_\_\_\_ Donating or collecting items for Walnut Hill (Magazines, meat trays, old cookie sheets, dress up Clothes, etc.)
15. \_\_\_\_\_ Share a special talent or hobby with the class. List talent/hobby: \_\_\_\_\_
16. \_\_\_\_\_ Please list other ideas here: \_\_\_\_\_



**Walnut Hill**  
Early Childhood Center

**Goshen Day Care Board, Inc.**

1700 Shasta Drive Goshen, Indiana 46526 · (574) 534-1884 · (574) 533-5482

**CONSENT FOR MEDIA RELEASE**

Child Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent/ Guardian Name \_\_\_\_\_

I hereby grant Walnut Hill Early Childhood Center to use my child's/families' likeness in photograph/ video and in all of its publications, including website entries and social media, without payment or any other consideration. I understand and agree that these materials will become the property of Walnut Hill Early Childhood Center and will not be returned. I hereby irrevocably authorize Walnut Hill Early Childhood Center to edit, alter, copy, exhibit, publish or distribute this photo/ video for purposes of publicizing Walnut Hill Early Childhood Center's program or any other lawful purpose. I authorize Walnut Hill Early Childhood Center to use the details of my personal story. In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness appears. Additionally, I waive any right to compensation arising or related to the use of the photograph/video.

I hereby hold harmless and release and forever discharge Walnut Hill Early Childhood Center from all claims, demands, and causes of action which I, my heir, representatives, executors, administrators, or any other person acting on my behalf or on behalf of my estate have by reason of this authorization. I have read this release before signing below and I fully understand the contents, meaning, and impact of this decision.

**Please read the following before signing:**

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/ Guardian Printed Name

