CHILD INFORMATION CARD

State of Delaware
Department of Education

Child's Information			
Child's name:	Date of birth:	Date of enrollment:	Date of discharge:
Child's address:		Hours and days child is scheduled to attend:	

Parent/Guardian Information (1) Emergency Contact/Authorized to Pick-up Child		Parent/Guardian Information (2) Emergency Contact/Authorized to Pick-up Child	
Name:		Name:	
Address, if different from child's:		Address, if different from child's:	
Home phone:	Cell phone:	Home phone:	Cell phone:
Work phone:	Hours of employment:	Work phone:	Hours of employment:
Employer name and address:		Employer name and address:	

Additional Emergency Contacts and People Authorized to Pick-up Child		
Name:	Address:	Phone:
Name:	Address:	Phone:
Name:	Address:	Phone:

☐ **Emergency Medical Care**

I, ______________________________, the parent (or legal guardian) of ________________________________, who is my minor child, hereby authorize emergency medical treatment for my child in the event I cannot be contacted to give permission to treat. I understand I will be financially responsible for the cost of such treatment.

☐ **Transportation**

I, ______________________________, the parent (or legal guardian) of ________________________________, who is my minor child, hereby give permission for my child to be transported by the licensee/staff/substitute.

_________________________________ _________________________________

Signature of parent/guardian Date

Medical Information	
Name of child's physician:	Office phone:
Special medical information, medications, allergies, diet:	Health insurance identification information:

The above information is necessary for your child's protection and this facility is required to have it. Keep this information current.

PARENTS RIGHT TO KNOW AND PERMISSIONS

Child's Name ________________________________

PARENTS RIGHT TO KNOW NOTICE

Per the Delaware code, you are entitled to inspect the active record and complaint files of any licensed child care facility. To review a record contact: the administrative specialist, Office of Child Care Licensing, 3411 Silverside Road, The Concord | Hagley Building, Wilmington, Delaware 19810, phone (302) 892-5800. You may also view substantiated complaints and compliance review histories for the past five years by visiting the Office of Child Care Licensing's child care search at https://education.delaware.gov/families/occl/child_care_search/.

I acknowledge I received this notice as part of the application packet.

________________________________ ________________
Parent/Guardian Signature **Date**

PARENT PERMISSION FOR SCREEN TIME USAGE

Children over the age of two may have an educational video, movie, or game incorporated into their curriculum. These may be viewed on a television, computer, tablet, or gaming device. These will be age-appropriate and limited to one hour per day unless a special occasion or activity occurs. Children will be closely supervised while using the internet.

I hereby authorize my child to have screen time activities.

________________________________ ________________
Parent/Guardian Signature **Date**

PARENT PERMISSION TO SLEEP ON A MAT

Children between the ages of 12 and 18 months will be transitioned from sleeping in a crib to a cot, mat, or bed when they are able to walk.

I hereby authorize my child to sleep on a cot, mat, or bed. ________________________________ ________________
Parent/Guardian Signature **Date**

RECEIPT OF PARENT HANDBOOK

I Certify that I have received information regarding the Center's polices on following topics: a typical daily schedule, positive behavior management techniques, routine and emergency health care, health exclusions, and prevention of communicable diseases, food and nutrition, procedures for releasing children, reporting of accidents, injuries or critical incidents, mandatory reporting of child abuse and neglect, administration of medication procedures, non-discrimination, developmental and educational goals, complaints, and transportation, if provided.

________________________________ ________________
Parent/Guardian Signature **Date**

Pirulo's Child Care & Learning Center
ENROLLMENT CONTRACT

Name: (Last) ______________________ (First) ______________________ (M.I) __________

Effective Date: ____________________ Hours Attending: From__________ To__________

Parent/Guardian Name: ____

Email: ____

Address: ______________________ City________________ State_____ Zip____________

Home # _______________ Mother's work # _______________ Father's work # _______________

Mother's cell # ____________________________ Father's cell # ________________________

Parent's Signature ____ Date ____________

Director's Signature ____ Date ____________

Weekly Tuition Rate $_______________ Registration Fee Paid: $__________

ALL TUITION IS DUE IN ADVANCE ON FRIDAY FOR THE UPCOMING WEEK

REGISTRATION FEE IS $40.00 PER CHILD. $55.00 FOR TWO CHILDREN.
$10.00 Discount for each additional child

AGE GROUP FULL-TIME RATES

1 YEAR OLD (12 MOS - 23 MOS) ____ $320.00
2-YEAR-OLD (24 MOS - 35 MOS) ____ $305.00
3 – 5-YEAR-OLD____ $295.00

Additional fees:

*Tuition Late Fee (if not paid on Friday) $30.00
*Late Pick-Up Fee: $2.00 per minute charge after 6pm

Pirulo's Child Care & Learning Center Photo Release Form

I, __________________________ hereby give my permission for my picture and/or my children's pictures to be taken and used for marketing and public relations purposes for the Pirulo's Child Care & Learning Center to be released to publications of the Pirulo's Child Care & Learning Center's choice.

______________________________ ______________________
Parent's Signature Date

Pirulo's Child Care & Learning Center

Give Your Child the Opportunity of a Second Language
799 Salem Church Road · Newark, DE 19702
Phone (302) 836-3520 · Fax (302) 836-3653

Policy Agreement

Fees: (All fees are not refundable)

1. Registration fee and 1st week tuition is due at time of enrollment.
2. All tuition and fees are due on Friday for the upcoming week. A late payment fee of $30.00 will be added to weekly tuition not paid in full by Monday morning. Holidays and absences are not deducted from weekly tuition payments.
3. Pirulo's Childcare is open Monday through Friday from 6 am to 6 pm. Parents who arrive after 6 pm, will pay a **$2 per minute** late pick-up fee. This fee must be paid at pick-up or at drop-off the following.
4. Returned checks are charged a $25 return check fee and a late fee must also be paid.

General Information:

1. The center will provide breakfast, lunch, and pm snack daily
2. The center will always provide child care in compliance with state regulation as well as the Office of Child Care Licensing.
3. The center will provide a curriculum using age-appropriate activities and toys for the children
4. The center will communicate with the parents about the needs and progress of their children
5. Parents must sign their child in/out of the center daily
6. Parents must call the center if their child will not attend or will be late. (After 9am)
7. Parents are responsible for bringing supplies for their children and must replenish the when needed:

   -Fitted crib sized sheet -Blanket -Wipes
   -Two (2) changes of clothes -Diapers/Pull-up
8. Two weeks' notice must be given in writing of any withdrawals from the center
9. Permission is given to take photographs of my child for Pirulo's Child Care & Learning Center use only.

Illness:

1. Children who become ill will be removed from the classroom. The parents will be notified and must make arrangements to pick up their child within **one (1) hour**. Sick children cannot be cared for by center. A physician's note (is applicable) for Pirulo's Child Care & Learning Center to administer medication.
2. Parents must sign medication log and provide physician's note (if applicable) for Pirulo's Child Care & Learning Center to administer medication.

I certify that I have received, read, understand and agree to abide by the policies set forth in the agreement.

Parent's signature________________________________ Date________________

Director's Signature_______________________________ Date________________

Pirulo's Child Care & Learning Center, LLC
Give Your Child the Opportunity of a Second Language
799 Salem Church Road · Newark, DE 19702
Phone (302) 836-3520 · Fax (302) 836-3653

Child's Name: ______________________________

SECURITY CODE

1. The keypad was installed to allow two members of the family or parents to have free access to the daycare between 6am and 6pm
2. The code should not be given to 3rd parties. This is for security reasons. This allows us to monitor 3rd parties when entering and leaving the building with a child.
3. Please DO NOT allow your child to use the code or any minor under the age of 18.
   - By orders of the fire marshal, we cannot lock the door from the inside. This is why the children are forbidden to touch the doors.
   - We do not want children to believe they can leave the building because they know the code.

____

Parent/Guardian Signature Date

CLASSROOM TRANSITION AGREEMENT

It is the policy of Pirulo's Child Care to follow the public-school schedule when moving a child to the next classroom. All children are transitioned in September.

When a child has a birthday, they can be moved only if space is available.

I, ____________________________, hereby sign with acknowledgment of this policy.

____

Parent/Guardian Signature Date

LIABILITY RELEASE FORM

In consideration of allowing the previously declared participant(s) to begin participation in Pirulo's Childcare activities, while on the premises and property of said Center, the undersigned, for themselves, and/or being the legal and acting guardian of participant(s), acting for themselves and on behalf of the participant(s), release and hold harmless Pirulo's Childcare, its owners, employees, and agents from any and all liability, claims, demands, and causes of action whatsoever, arising out of or related to any loss, damage, or injury, that may be sustained by the participant, while in or upon the premises upon which Pirulo's Childcare is conducted.

____

Parent/Guardian Signature Date

STATE OF DELAWARE
DEPARTMENT OF EDUCATION
OFFICE OF CHILD CARE LICENSING (OCCL)

NAME____________________

Family Child Care Home
Large Family Child Care Home
Day Care Center
Youth Camp

BIRTHDATE___________

CHILD HEALTH APPRAISAL

SECTION A: TO BE COMPLETED BY PARENT BEFORE PHYSICAL EXAMINATION

CHECK IF CHILD HAS PROBLEMS WITH ANY OF THE FOLLOWING: GIVE ADDITIONAL COMMENTS BELOW

☐ Allergies (food, medicine, bee sting etc.)	☐ Frequent Colds	☐ Fainting	☐ Physical Handicap
	☐ Hearing Difficulty	☐ Speech Difficulty	☐ Behavior Problem
☐ Constipation/Diarrhea	☐ Seizures	☐ Vision Difficulty	☐ Asthma

Other____

Comments:____

ADDITIONAL INFORMATION ABOUT YOUR CHILD (include serious illness, accidents, operations, medications, etc. with dates):____

Parent/Guardian's Signature________________________ Date______________

SECTION B: TO BE COMPLETED BY EXAMINING PHYSICIAN/PEDIATRIC NURSE PRACTITIONER

CODE: X - Within Normal Limits O - See Remarks Below

_____ Scalp, Skin	_____ Heart	_____ Vision	_____ Ear, Nose	_____ Lungs
_____ Hearing	_____ Throat	_____ Abdomen	_____ Blood Pressure	_____ Eyes
_____ Genitalia	_____ Teeth	_____ Extremities	_____ Neck, Glands	_____ Nervous System
_____ Height	_____ Weight			

REMARKS AND RECOMMENDATIONS: ____

IS CHILD PROGRESSING NORMALLY FOR AGE GROUP? ____________________________

DTP/Hib 1 / /	DTP/Hib 2 / /	DTP/Hib 3 / /	DTP/ Hib 4 / /	DTaP/Hib 4 / /
DTP/DTaP 1 / DT / /	DTP/DTaP 2 / DT / /	DTP/DTaP 3 / DT / /	DTP/DTaP 4 / DT / /	DTP/DTaP 5 / DT / /
Td 1 / /	Td 2 / /	Td 3 / /	/ /	/ /
OPV/IPV 1 / /	OPV/IPV 2 / /	OPV/IPV 3 / /	OPV/IPV 4 / /	TB Screening 12 mo / /
MMR 1 / /	MMR 2 / /	HepB 1 / /	HepB 2 / /	HepB 3 / /
Hib 1 / /	Hib 2 / /	Hib 3 / /	Hib 4 / /	Hep B/Hib 1 / /
Hep B/Hib 2 / /	Hep B/Hib 3 / /	Varicella 1 / /	Varicella 2 / /	Influenza 1 / /
Influenza 2 / /	Pneumococcal Polysaccharide1 / /	Pneumococcal Polysaccharide 2 / /	Pneumococcal Conjugate 1 / /	Pneumococcal Conjugate 2 / /
Pneumococcal Conjugate 3 / /	Pneumococcal Conjugate 4 / /	Hep A 1 / /	Hep A 2 / /	Lyme Vax 1 / /
Lyme Vax 2 / /	Lyme Vax 3 / /	Other: / /	Lead Screening 12 mo / /	Lead Screening 24 mo / /

Examiner's Signature______________________ ☐ M.D. ☐ P.N.P. Date:______________

Printed Name:______________________ Telephone:______________________

MEDICATION ADMINISTRATION RECORD (MAR)
(FOR MEDICATIONS GIVEN AS NEEDED OR FOR EMERGENCY USE)

CHILD'S NAME: ____________________ DOB: ________ ALLERGIES: ____________________

PARENT'S/GUARDIAN'S NAME: ____________________ DOCTOR: ________________ TELEPHONE: __________

MEDICATION INFO	**TIME:**	**DATE:**	**NAME OF PERSON ADMINISTERING:**
MEDICATION NAME: Children's Motrin			
DOSAGE:			
ROUTE: Oral			
REASON: Fever Reducer			
START DATE:			
SPECIAL INSTRUCTIONS:			

ROUTE OF ADMINISTRATION; SELECT ONE

ORAL *(BY MOUTH)*
EYE DROPS *(OPTIC)*
NOSE DROPS/SPRAY *(NASAL)*
EAR DROPS *(OTIC)*
TOPICAL *(ON SKIN)*
INHALATION (*NEBULIZER)*
INJECTION (*SYRINGE, PEN, OR ELECTRONIC INFUSION DEVICE)*
RECTAL

Dates and times of sunscreen, diaper cream, and insect repellent applications do not need to be documented. However, all other information and parent permission for these medications are required on the MAR.

I, ______________________________, the parent/guardian of the above listed child, give permission for the above medication to be administered.

______________________________ ______________________________
Signature Date

DATE:	**TIME:**	**COMMENTS/MEDICATION ERRORS/ADVERSE EFFECTS:**	**DATE AND TIME PARENT/GUARDIAN INFORMED OF ERRORS OR ADVERSE EFFECTS**

MEDICATION ADMINISTRATION RECORD (MAR)
(FOR MEDICATIONS GIVEN AS NEEDED OR FOR EMERGENCY USE)

CHILD'S NAME: ______________________ DOB: __________ ALLERGIES: ______________________

PARENT'S/GUARDIAN'S NAME: ______________________ DOCTOR: ______________ TELEPHONE: __________

MEDICATION INFO	TIME:	DATE:	NAME OF PERSON ADMINISTERING:
MEDICATION NAME: Children's Tylenol			
DOSAGE:			
ROUTE: Oral			
REASON: Fever Reducer			
START DATE:			
SPECIAL INSTRUCTIONS:			

ROUTE OF ADMINISTRATION; SELECT ONE

ORAL *(BY MOUTH)*
EYE DROPS *(OPTIC)*
NOSE DROPS/SPRAY *(NASAL)*
EAR DROPS *(OTIC)*
TOPICAL *(ON SKIN)*
INHALATION (*NEBULIZER)*
INJECTION (*SYRINGE, PEN, OR ELECTRONIC INFUSION DEVICE)*
RECTAL

Dates and times of sunscreen, diaper cream, and insect repellent applications do not need to be documented. However, all other information and parent permission for these medications are required on the MAR.

I, ______________________, the parent/guardian of the above listed child, give permission for the above medication to be administered.

______________________ Signature

______________________ Date

DATE:	TIME:	COMMENTS/MEDICATION ERRORS/ADVERSE EFFECTS:	DATE AND TIME PARENT/GUARDIAN INFORMED OF ERRORS OR ADVERSE EFFECTS

MEDICATION ADMINISTRATION RECORD (MAR)
(FOR MEDICATIONS GIVEN AS NEEDED OR FOR EMERGENCY USE)

CHILD'S NAME: ____________________ DOB: __________ ALLERGIES: ____________________

PARENT'S/GUARDIAN'S NAME: ____________________ DOCTOR: ____________________ TELEPHONE: __________

MEDICATION INFO	TIME:	DATE:	NAME OF PERSON ADMINISTERING:
MEDICATION NAME: Neosporin			
DOSAGE: Ointment			
ROUTE: Topical (Skin)			
REASON: First Aid Antibiotic			
START DATE:			
SPECIAL INSTRUCTIONS:			

ROUTE OF ADMINISTRATION; SELECT ONE

ORAL *(BY MOUTH)*
EYE DROPS *(OPTIC)*
NOSE DROPS/SPRAY *(NASAL)*
EAR DROPS *(OTIC)*
TOPICAL *(ON SKIN)*
INHALATION *(NEBULIZER)*
INJECTION *(SYRINGE, PEN, OR ELECTRONIC INFUSION DEVICE)*
RECTAL

Dates and times of sunscreen, diaper cream, and insect repellent applications do not need to be documented. However, all other information and parent permission for these medications are required on the MAR.

I, ____________________, the parent/guardian of the above listed child, give permission for the above medication to be administered.

____________________ Signature

____________________ Date

DATE:	TIME:	COMMENTS/MEDICATION ERRORS/ADVERSE EFFECTS:	DATE AND TIME PARENT/GUARDIAN INFORMED OF ERRORS OR ADVERSE EFFECTS

MEDICATION ADMINISTRATION RECORD (MAR)
(FOR MEDICATIONS GIVEN AS NEEDED OR FOR EMERGENCY USE)

CHILD'S NAME: ______________________ DOB: __________ ALLERGIES: ______________________

PARENT'S/GUARDIAN'S NAME: ______________________ DOCTOR: ______________ TELEPHONE: __________

MEDICATION INFO	TIME:	DATE:	NAME OF PERSON ADMINISTERING:	ROUTE OF ADMINISTRATION; SELECT ONE
MEDICATION NAME: Vicks Vapo Rub				ORAL *(BY MOUTH)*
DOSAGE: Ointment				EYE DROPS *(OPTIC)*
ROUTE: Topical (Skin)				NOSE DROPS/SPRAY *(NASAL)*
REASON: Cough Suppressant				EAR DROPS *(OTIC)*
START DATE:				TOPICAL *(ON SKIN)*
SPECIAL INSTRUCTIONS:				INHALATION (*NEBULIZER)*
				INJECTION (*SYRINGE, PEN, OR ELECTRONIC INFUSION DEVICE)*
				RECTAL

Dates and times of sunscreen, diaper cream, and insect repellent applications do not need to be documented. However, all other information and parent permission for these medications are required on the MAR.

I, ______________________, the parent/guardian of the above listed child, give permission for the above medication to be administered.

______________________ ______________________
Signature Date

DATE:	TIME:	COMMENTS/MEDICATION ERRORS/ADVERSE EFFECTS:	DATE AND TIME PARENT/GUARDIAN INFORMED OF ERRORS OR ADVERSE EFFECTS

MEDICATION ADMINISTRATION RECORD (MAR)
(FOR MEDICATIONS GIVEN AS NEEDED OR FOR EMERGENCY USE)

CHILD'S NAME: ______________________ DOB: __________ ALLERGIES: ______________________

PARENT'S/GUARDIAN'S NAME: ______________________ DOCTOR: ______________ TELEPHONE: __________

MEDICATION INFO	TIME:	DATE:	NAME OF PERSON ADMINISTERING:
MEDICATION NAME: Vaseline			
DOSAGE: Ointment			
ROUTE: Topical (Skin)			
REASON: Skin Protectant			
START DATE:			
SPECIAL INSTRUCTIONS:			

ROUTE OF ADMINISTRATION; SELECT ONE

ORAL *(BY MOUTH)*
EYE DROPS *(OPTIC)*
NOSE DROPS/SPRAY *(NASAL)*
EAR DROPS *(OTIC)*
TOPICAL *(ON SKIN)*
INHALATION (*NEBULIZER)*
INJECTION (*SYRINGE, PEN, OR ELECTRONIC INFUSION DEVICE)*
RECTAL

Dates and times of sunscreen, diaper cream, and insect repellent applications do not need to be documented. However, all other information and parent permission for these medications are required on the MAR.

I, ______________________, the parent/guardian of the above listed child, give permission for the above medication to be administered.

______________________ Signature

______________________ Date

DATE:	TIME:	COMMENTS/MEDICATION ERRORS/ADVERSE EFFECTS:	DATE AND TIME PARENT/GUARDIAN INFORMED OF ERRORS OR ADVERSE EFFECTS

MEDICATION ADMINISTRATION RECORD (MAR)
(FOR MEDICATIONS GIVEN AS NEEDED OR FOR EMERGENCY USE)

CHILD'S NAME: ______________________ DOB: __________ ALLERGIES: ______________________

PARENT'S/GUARDIAN'S NAME: ______________________ DOCTOR: ________________ TELEPHONE: __________

MEDICATION INFO	TIME:	DATE:	NAME OF PERSON ADMINISTERING:	ROUTE OF ADMINISTRATION; SELECT ONE
MEDICATION NAME:				ORAL *(BY MOUTH)*
				EYE DROPS *(OPTIC)*
DOSAGE:				NOSE DROPS/SPRAY *(NASAL)*
ROUTE:				EAR DROPS *(OTIC)*
REASON:				TOPICAL *(ON SKIN)*
START DATE:				INHALATION (*NEBULIZER)*
SPECIAL INSTRUCTIONS:				INJECTION (*SYRINGE, PEN, OR ELECTRONIC INFUSION DEVICE)*
				RECTAL

Dates and times of sunscreen, diaper cream, and insect repellent applications do not need to be documented. However, all other information <u>and parent permission</u> for these medications are required on the MAR.

I, ______________________________, the parent/guardian of the above listed child, give permission for the above medication to be administered.

______________________________ ______________________________
Signature Date

DATE:	TIME:	COMMENTS/MEDICATION ERRORS/ADVERSE EFFECTS:	DATE AND TIME PARENT/GUARDIAN INFORMED OF ERRORS OR ADVERSE EFFECTS

Pirulo's Child Care & Learning Center, LLC

Give Your Child the Opportunity of a Second Language

799 Salem Church Road · Newark, DE 19702

Phone (302) 836-3520 · Fax (302) 836-3653

AUTOMATIC DEBIT AUTHORIZATION FORM

Dear Parents,

If you would like to enjoy the convenience of automatic recurring billing, simply complete the debit card information section below and sign form.

All requested information is required: we will automatically bill your debit for the amount indicated and your total charges will appear on your monthly checking statement. You may cancel this automatic billing authorization at any time by contacting us.

CUSTOMER INFORMATION:

Name: ______________________ **Child's Name:** ______________________

Address: ______________________ **Phone:** ______________________

______________________ **Email:** ______________________

PAYMENT INFORMATION:

I authorize Pirulo's Child Care to automatically bill the card listed below as specified:

Product/Service: Child Care

Amount: ______________

Frequency: One-Time / Weekly / Biweekly / Monthly

Start On: _____/_____/_______ End On: _____/_____/_______

CARD INFORMATION:

Card Type: Visa / Master Card / Other: ______________

CVV: _________

Card Holder Name: ______________________

Card Number: ______________________ Expires: ______/______

______________________ ______________

Signature Date