Little People's Learning Center
Update Form

Center Use Only
Name:
Date of intake: ___/____/_____

Child's Name:_____ DOB:_____

Please fill out the following information about your child, even if you have filled it out previously

Contact

Has your information (work, phone number, address etc.) changed in the last year? If so, what has changed?

_____

_____

Eating Habits

At home, does your child eat: ☐ held in lap ☐ highchair ☐ at table ☐ other

Does your child eat unassisted using: ☐ fingers ☐ spoon ☐ fork ☐ knife

Does your child drink from: ☐ bottle ☐ sippy cup ☐ open cup

Eating habits that you are concerned with? _____

Any medical or religious dietary restrictions? _____

Toilet Routines

Does your child still use diapers or pull ups at any time of day? ☐ Yes ☐ No

If so, when do they use them (check any that apply): ☐ during the day ☐ for nap ☐ at night

If your child uses the toilet, do they require any form of assistance (ex: help wiping, help getting on, etc.)

Accessibility and Accommodation

Does your child receive therapeutic services in a developmental center or school? _____

Where? _____

What services?

Authorized Adults

The following people will be authorized to pick up your kids. If there are no changes, please write "no changes" and we will keep the current authorizations.

Name	Relationship	Phone

Emergency contact

In cases of emergency, parents or guardians will be notified as soon as possible. In the event we cannot reach a parent or guardian, who else should we contact?

Name: _____

Relationship to child: _____ Phone: _____

Parents are responsible for all costs associated with emergency medical treatments.

Healthcare Provider Information

Physician:		**Phone:**	
Dentist:		Phone:	
Other:		Phone:	

Insurance Information

Insurance Company:			
Name of Subscriber:		Plan number	

List all hospitalizations or chronic illnesses:

_____

_____

Which communicable illnesses (chicken pox; hand, foot, mouth; measles; scabies) has your child had: _____

_____

Is your child currently on medication? ☐ Yes ☐ No

If yes, name of medication(s): _____

What condition is this medication taken to treat? _____

Allergies

Type	Allergen	Reaction
Medications:		
Food(s):		
Bee stings:		
Respiratory:		
Other:		

Are any of the allergies severe or life-threatening? ☐ Yes ☐ No (If yes, please talk to your Center Director about completing an allergy plan.)

_____ _____

Parent/guardian signature Date

Emergency Medical Care Release

In case of an emergency, I understand that center staff will attempt to contact me immediately. I also authorize center staff to:

- Consult the physician or dentist named above.
- Administer first aid and/or cardiopulmonary resuscitation.
- Transport my child via ambulance or other emergency medical service to a local hospital or other urgent care facility.
- Obtain any emergency medical, surgical or dental treatment deemed necessary by medical authorities.
- Transport my child to a local emergency shelter in the event of an emergency evacuation of the center.

_____ _____

Parent/guardian signature Date

LPLC Agreement

I consent to the enrollment of the child listed below in this facility and have been advised of the policies regarding administration of medications, fees, transportation and the services provided by the facility, as outlined in this handbook. I will promptly update any information provided to the center about my child's health, contact information, or other information changes. I acknowledge that a child may be un-enrolled by the center without prior notice if, in the sole opinion of the center, it is in the best interest of the child or the center.

Financial Obligations

- As the parent/guardian signing this Enrollment Agreement all amounts due are ultimately my responsibility.
- Overdue accounts may be referred to a collection agency. I am responsible for all account balances, plus reasonable collection and attorney fees associated with the collection of the account.
- All families are required to have a current form of payment on file. I give permission for LPLC to charge this account in the event that there is an outstanding balance on my account on or after the due date. I can change this information at any time, but must provide at least 14 days notice of any change.
- Payments from families with prior unpaid, returned checks or multiple late payments must be in the form of automatic deposits. Families with returned payments may be subject to immediate termination of services and are responsible for any associated fees.
- Any prepaid balance of $25 or less which remains at the time of mychild's un-enrollment will not be refunded unless requested in writing within 90 days.
- Thirty days written notice is required prior to the last day of attendance. If I do not give thirty days written notice of withdrawal, I agree to pay full tuition and fees due for the final month regardless of my child's attendance.

LPLC reserves the right to alter policies and/or program at any time. The terms of this agreement, including the tuition and fees, are subject to change in whole or in part by the center with 30 days' notice.

Child's Name:			
Parent Signature:		Date:	

Permission Slips*Please fill all permissions out for each child individually!

I give permission for staff of Little People's Learning Center to take my child on walking field trips off the Little People's property for the 2020-2021 School Year and Summer 2021.			
Child's Name:			
Parent Signature:		Date:	

I give permission for Little People's Learning Center to appropriately photograph my child and share those pictures with LPLC families (as in weekly updates or in invite-only photo folders)			
Child's Name:			
Parent Signature:		Date:	

I give permission for Little People's Learning Center to appropriately photograph my child and utilize those pictures to share on the center's website, social media accounts and marketing materials.			
Child's Name:			
Parent Signature:		Date:	

I give permission for my child_____to drink pasteurized milk: (Please check one)

- ❑ At all meals, including snack.
- ❑ At lunch only.
- ❑ Only the milk I provide.
- ❑ No milk due to allergy.
- ❑ No milk due to preference.

Parent Signature:		Date:	
Parent Signature:		Date:	

OVER THE COUNTER (OTC) MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY PARENT

Child's Name_____Date of Birth_____/____/___
Program Name_____Today's Date_____/____/___

****

I give permission for the administration of following non-ingestible over the counter medications (mark all that apply):

☐ Diaper Rash Cream/Ointments

☐ Insect Repellent

☐ Sunscreen

☐ Cortisone/Anti-Itch Creams/Ointments

☐ Medicated Lip Treatments

☐ OTC Antibiotic Creams/Ointments

☐ Teething Tablets/Ointments

☐ Burn Creams/Sprays

☐ Other Non-Ingestible OTC's: (Please Specify)_____

- ☐ _____
- ☐ _____
- ☐ _____

To administer a non-ingestible over the counter (OTC) medication:

- The OTC medication must be brought to the day care facility from the parent;
- The OTC medication must be in its original container, with a legible label, and expiration date of medication;
- The child's name must be on the original container

Special handling/storage Instructions_____Refrigeration Y/N

Parent/Guardian Signature (required)_____

*** This document must be updated on an annual basis.**

Unused Medication: Returned to Parent Y/N or Discarded Appropriately (circle one)

By: _____ Date _____/_____/_____

***Keep in the child's file when medication is finished**.