Southwest Campus Child Care Programs

Macon Campus | Campus Kid's Corner | 5990 Resources Drive, Memphis, TN 38128
Union Campus |Early Childhood Education Learning Center | 717 Beale Street, Memphis, TN 38103

Child's Name: _____ Sex: _____ Age:_____ Date of birth: _____

Home Address: _____ Apt #:_____ City: Memphis State: TN Zip: _____

Home Phone Number: _____

Mother's Name: _____ Home Phone Number: _____

Mother's Home Address (if different from child's) _____ Apt #:____ City: Memphis State: TN Zip:

Mother's Place of Employment: _____ Work Phone: _____

Employer's Street Address: _____ City: _____ State: _____ Zip: _____

Father's Name: _____ Home Phone Number: _____

Father's Home Address (if different from child's) _____ Apt #:____ City: Memphis State: TN Zip:

Father's Place of Employment: _____ Work Phone: _____

Employer's Street Address: _____ City: _____ State: _____ Zip: _____

___ (School age student only) my child's shot record is on file at their school.

Child's Living Arrangements: (check one) ( ) Both Parents ( ) Mother ( ) Father ( ) Other

Child's Legal Guardian(s): (check one) ( ) Both Parents ( ) Mother ( ) Father ( ) Other

RELEASE PLAN: **The child may be released to the person(s) signing this agreement or to the following:**

1 Name: Address: City: State: Zip:_____

Telephone Number: Relationship to child: _____

2 Name: Address: City: State: Zip:_____

Telephone Number: Relationship to child: _____

3 Name: Address: City: State: Zip:_____

Telephone Number: Relationship to child: _____

Persons to contact in the case of emergency when parent or guardian cannot be reached:

Name: _____ Telephone Number: _____
Name: _____ Telephone Number: _____
Name: _____ Telephone Number: _____

- **Name of Public or Private School child attends, if any: _____**
- **Child's doctor or clinic name:_____ Phone Number: _____**

My child has the following special needs:

- _____ _____
- _____ _____

The following special accommodation(s) may be required to most effectively meet my child's needs while at the center:

- _____ _____
- _____ _____

My child is currently on prescribed medication(s) for long-term continuous use and/or has the following preexisting illness, allergies, or health concerns: (We do not issue over-the-counter medications without a doctor's statement)

- _____ _____
- _____ _____

EMERGENCY MEDICAL AUTHORIZATION PLAN:

Should (child's name)_____ Date of birth: _____ suffer an injury or illness while in the care of this agency and the facility is unable to contact me (us) immediately, it shall be authorized to secure such medical attention and care for the child as may be necessary. I (We) shall assume responsibility for payment for services.

Parental Enrollment Addendum Agreements with the Child Care Agency | CACFP

This agency agrees to provide child care and meals for the student listed above. (We are open year-round)

Macon Campus | MONDAY through **FRIDAY** **School Year Hours** 7:00a.m. to 4:30p.m.

Union Campus | MONDAY through **FRIDAY** **School Year Hours** 7:00a.m. to 5:30 p.m.

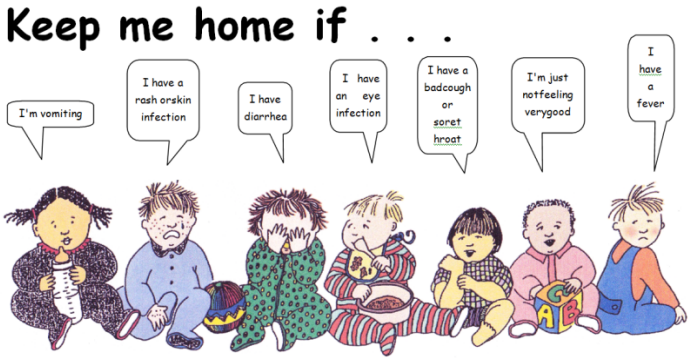
My child will participate in the following meal plan: **AM Supplement, Lunch and PM Supplement.**

Parent/Guardian Signature: _____ Date: _____

Facility Administrator Signature: _____ Date: _____

All About Me!

- Child's Name: _____
- Nickname: _____
- I have: _____ brothers & _____ sisters
- Has your child been in child care before? ( ) Yes ( ) No.
    - If yes, please give last child care provider, or daycare center's information: Name: _____
    - Dates Attended: from _____ to _____
    - Why was care terminated? _____
- Does your child have a regular bedtime schedule? ( ) Yes ( ) No.
- What time does your child usually go to bed at night? _____
- What time does your child usually wake up in the morning? _____
- Does your child have trouble sleeping? ( ) Yes ( ) No.
- Night Terrors? ( ) Yes ( ) No.
- Trouble going to sleep? ( ) Yes ( ) No.
- If infant how does your child sleep? ( ) Stomach ( ) Side ( ) Back.
- What time(s) and for how long does your child usually nap? _____
- Are there any special dolls, blankets, etc that your child needs to go to sleep? ( ) Yes ( ) No
- What is your child's disposition upon waking? ( ) Happy ( ) Grouchy ( ) Clingy ( ) Slow
- Has or does your child have any known health problems? ( ) Yes ( ) No.
    - If yes, please describe:_____



ILLNESSES REQUIRING EXCLUSION FROM DAYCARE

Fever, defined by the child's age as follows until medical evaluation indicates inclusion:
- Infants 4 months old and younger – rectal temperature greater than 101° F or auxiliary (armpit) temperature greater than 100° F even if there is no change in their behavior.
- Infants and children older than 4 months (accompanied by behavior changes or other signs or symptoms of illness) – rectal temperature of 102° F or greater, oral temperature of 101° F or greater, or auxiliary (armpit) temperature of 100° F or greater.

Signs possible severe illness, including unusual lethargy, irritability, persistent crying, difficult breathing.

Uncontrolled diarrhea, defined as an increased number of stools compared with the child's normal pattern, with increased stool water and/or decreased form that is not contained by the diaper or toilet use.

Infestation (e.g., scabies, head lice), until 24 hours after treatment was begun.

Tuberculosis, until the child's physician or local health department authority states the child is non-infectious.

Impetigo, until 24 hours after treatment was begun.

Streptococcal pharyngitis, until 24 hours after treatment has been initiated, and until the child has been afebrile for 24 hours.

Ringworm infection (tinea capitis, tinea corporis, tinea crusis, and tinea pedis) until 24 hours after treatment was begun.

Shingles, only if the sores cannot be covered by clothing or a dressing, until the sores have crusted.