Child Emergency Contact Information Card

Childs Name_____ Childs Date of Birth_____

Childs Address_____

Parents Names and Relationship to Child

_____

Preferred contact information (i.e., phone number and email address)

_____

_____

Alternate Emergency Contacts_____

Individuals Authorized for pick-up_____

List all special instructions for children with disabilities or chronic medical conditions_____

Any Known allergies_____

nisse
treehouse LLC
CHILDCARE AND PRESCHOOL

Enrollment for Child Care Packet

This is a required piece of information as determined by Nisse Treehouse Childcare & Preschool's state licensor. It must be filled out in its entirety. Students will not be permitted into care without completing this packet.

Child's name: _____ D.O.B._____

Expectant child's due date_____

Start Date: _____ End Date: _____

Mother's Full Name: _____ Cell #:_____

Mother's Address: _____

Mother's Email Address: _____

Father's Full Name: _____ Cell #:_____

Father's Address: _____

Father's Email Address: _____

Child's Address: _____

Mother's place of Employment: _____ #:_____

Address: _____

Father's place of employment: _____ #:_____

Address: _____

Please provide a list of responsible adults NT Childcare may call if parents cannot be reached. These adults may drop off/or pick up your child. We ask that those listed also provide a photo ID until the staff becomes familiar with them. An "Authorized to Pick Up" form must be completed to allow anyone other than those listed below to pick up your child. These people may also be contacted in case of an emergency if parents cannot be reached.

1._____ Relation:_____ #_____

Address:_____

2._____ Relation:_____ #_____

Address:_____

If child is an infant, amount of water usually given by parent: _____

If child is under one year of age, amount of formula/milk, solid foods and feeding schedule*: _____

_____

Effective methods for comforting your child that could be useful for us to know: _____

_____

What is your family's home language? _____

Does your child have an IEP* (Individual Education Plan)? _____

Does your child have an IFSP* (Individual Family Service Plan)? _____

Does your child use CCAP* for tuition support? _____

Child's Health History:

Does your child have any known health concerns? _____

Does your child have any known allergies? _____

Does your child take any medication? _____

Any other comments/concerns/ideas: _____

_____

_____

_____

***Additional forms may be needed**

CHILD PROFILE FORM

Child's Name-_____ Date of Birth _____ Gender_____

Does your child have a nickname? _____

My child will be attending care:

Monday	To
Tuesday	To
Wednesday	To
Thursday	To
Friday	To

Getting to know you and your child: Check here if you are expecting_____

Mom: _____ Dad: _____

Siblings: _____

What do you find most important about your child's environment while in our care? _____

_____

What is important to in regards to our staff? _____

_____

Napping Habbits: _____

Eating Habits/Dietary
Restrictions*:_____

Child's Temperament: _____

Educational Concerns: _____

Is your child potty-trained? Yes No If so, what methods work for your child? If not, please let us know when you start so we can support your child at the Center.

_____

Diapering/Toileting procedures: _____

Does your child have any communication habits that we should know about? _____

_____

Food Likes and Dislikes: _____

Physical or health problems to be watched*:_____

Consent for Emergency Treatment

I hereby give permission for my child, _____, to receive emergency treatment (first aid and CPR) by any of the qualified staff members Nisse Treehouse Childcare Center.

I also give permission for the center staff to act in the case of an emergency, or when a parent cannot be reached or is delayed. I give permission for my child to be transported by ambulance, aid care or staff vehicle to an emergency center for treatment.

In an event that I cannot be contacted, I further consent to the medical, surgical and hospital care treatment and procedure to be performed for my child by a licensed physician or hospital when deemed immediately necessary to safeguard my child's health.

In case of an emergency, I agree to pay all costs of transportation and all medical costs.

Child's physician: _____

Physician's phone#: _____

Physician's address: _____ Hospital: _____

Medical Insurance: _____ Medical #: _____

Dentist Name: _____ Dentist phone #: _____

Signatures: Mother: _____ Date: _____

Father: _____ Date: _____

**This form is given to teachers/ or photocopied to place in their First Aid which is taken with them on walks, field trips or in the event of an emergency. This ensures we always have contact information. Please make sure you update your teacher/ NT Childcare if you change this information. Please complete all blanks completely. Thank you.

Child full name: _____ D.O.B: _____

Mother's full name: _____ Cell #: _____

Father's full name: _____ Cell #: _____

Child's Address: _____ Email: _____

Mother's place of employment: _____ #: _____

Father's place of employment: _____ #: _____

Signatures & Permission

I, _____ (Parent/Guardian) have read and understand ALL of Nisse Treehouse Childcare Center's policies. I understand that if I do not have copies of said policies, that it is my responsibility to ask the director for copies.

The policies that I have read and understand are as follows:

__ Tuition policy
__ Illness policy
__ Health and Safety policies and procedures
__ Behavior Guidance policy
__ Infant policy (if applicable)
__ Meals and Snacks policy
__ Naps and Rest policy
__ Mandated Reporter policy
__ Privacy Policy
__ Child Care Program Plan
__ Open Door policy
__ Grievance Procedure
__ Physical Activity Policy
__ Electronic Communication Policy

- By signing this form I state that I understand Nisse Treehouse Policies and Procedures are reevaluated and are subject to change. I understand that Nisse Treehouse will inform me of policy changes by posting them on the "Communication Board" for 2 weeks.
- By signing this form, I give Nisse Treehouse staff permission to assist my child in his/her diapering and toileting needs.
- **By signing this form, I give Nisse Treehouse staff permission to administer sunscreen, diaper ointment, bug repellant, Chap Stick, lotions, etc. that I have provided them for use. I also authorize the use of hand sanitizer or wipes if needed.**
- By signing this form, I give Nisse Treehouse Childcare' director permission to enter immunization records of my child into the Minnesota Immunization Information Connection database in the event my child's immunization records have not already documented.

Parent/Guardian_____ Date: _____

Photograph Release

By signing this form I state that I understand pictures of my child may be taken for use within Nisse Treehouse, that local media including newspapers and television stations occasionally do feature stories on our center and our activities. Photos and videos may be taken for these purposes as well as for our bulletin boards, scrapbooks, community presentations, and our website/internet media.

Parent/Guardian_____Date:_____

Neighborhood Walk Permission Form

An important part of our curriculum includes walks in the neighborhood and field trips into the community. These are excellent means of expanding children's knowledge of the world around them. Walks may even include trips to the Spring Grove Public Library. Other field trips to specific places will require special permission.

Parent/Guardian_____Date:_____

Additional Authorized Pick-Up Persons

These names are different from those listed on the Enrollment Form. These people must have an ID number to enter the Center and present a Photo ID at the time of pick up.

Name: _____ Relationship: _____

Address: _____

Phone: Home: _____ Work: _____ Cell: _____

Name: _____ Relationship: _____

Address: _____

Phone: Home: _____ Work: _____ Cell: _____

Name: _____ Relationship: _____

Address: _____

Phone: Home: _____ Work: _____ Cell: _____

Name: _____ Relationship: _____

Address: _____

Phone: Home: _____ Work: _____ Cell: _____

How did you hear about Nisse Treehouse?

- **Newspaper**
- **Radio**
- **Television**
- **A friend**
- **A family member**
- **Website**
- **Other:** _____

Infant Intake Form

Nisse Treehouse LLC

For Children Under 1 Years

Child Name(first, middle, last):_____ **Birth Date:**_____

Parents Names:_____ **Date filled out:**_____

HEALTH: **Child has frequent colds, ear infections, colic, etc. – If yes, please describe. Any surgeries?**
MEALS: **Current Feeding Schedule:**
Length of Time on Current Schedule:
Food Type: **____ Breast Milk ____Formula ____Infant cereal ____Table food ____Other-please describe** _____Baby food How often is child fed:
When eating, child is: ____Held in lap ____In highchair ____Other-please describe
Feeds Self: ____Yes ____No
Special Feeding Problems: ____Yes____No **If yes, please describe:**
Food Allergies: ____Yes ____No **If yes, please describe:**
Favorite Foods:
Refused Foods:
Updates:

Nisse Treehouse Scheule

Monday-Friday

7:00am-5:30pm

Child Name:_____

Start Date:_____

Day of Week	Drop Off	Pick Up
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

*Provide a general schedule. If the child's schedule alternates every other week, please fill out another schedule and provide the weeks they will apply.

*Please provide Darcy with a 2 week notice (if possible) with any scheule changes.

* Please message in Procare (infants or toddlers) with any last minute changes in scheule; early/ late drop off or pick up, vacation days, doctors appts, etc. Preschool parents, tell Chloe as early as possible or as soon as you know.

Parent Signature:_____Date:_____

HEALTH CARE SUMMARY

Date of Enrollment: _____

NAME OF CHILD _____ Birth Date _____

ADDRESS _____ Telephone _____

PARENT(S) OR
GUARDIAN _____

Date of last physical examination _____ How long have you been seeing this child? _____

How frequently do you see this child when he/she is not ill? _____

Does this child have any allergies (including allergies to medications)?

_____

_____

Is a modified diet necessary?

_____

Is any condition present that might result in an emergency?

_____

_____

What is the status of the child's. . . Vision _____
Hearing _____
Speech _____

Please list below the important health problems

Followed By You	Followed By Other Med Source (Name)	Requires Special Attention at Center
__	__	__

Important Health Problems:

_____

_____

_____

Other information helpful to the child care program _____

_____

_____

_____

Signature of Health Source _____

Address _____

Phone _____ Date _____

MS-2083

Enter the dates for each vaccine your child has received to date. Specify the month, day, and year of each dose such as 01/01/2010.

Immunization Form

Name_____ Birthdate_____

Immunizations required for child care, early childhood programs, and school.

Vaccine	Birth to 6 months			12 -24 months		At Kindergarten	At 7th grade	At 12th grade
Hepatitis B								
Diphtheria, Tetanus, Pertussis (DTaP, DT, Td)								
Haemophilus influenzae type b (Hib)								
Pneumococcal (PCV)								
Polio								
Measles, Mumps, Rubella (MMR)								
Chickenpox (varicella)								
Hepatitis A								
Tetanus, Diphtheria, Pertussis (Tdap)								
Meningococcal (MCV4)								

Minnesota law requires children enrolled in child care, early childhood education, or school to be immunized against certain diseases, unless the child is medically or non-medically exempt.

Instructions for parent or guardian:

1. Fill out the dates in chronological order even if your child received a vaccine outside of the age/grade category that the box is in. Depending on the age of your child, they may not have received all vaccines; some boxes will be blank.
   - If you have a copy of your child's immunization history, you can attach a copy of it instead of completing the front of this form.
   - Your doctor or clinic can provide a copy of your child's immunization history. If you are missing or need information about your child's immunization history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-3980 or 800-657-3970.
2. Sign or get the signatures needed for the back of this form.
   - Document medical and/or non-medical exemptions in section 1.
   - Verify history of chickenpox (varicella) disease in section 2.
   - Provide consent to share immunization information (optional) in section 3.

DEPARTMENT OF HEALTH
Immunization Program (2019)
www.health.state.mn.us/immunize

Instructions: Complete section 1 to document a medical or non-medical exemption, section 2 to verify history of varicella disease, and section 3 to consent to share immunization information.

Name _____

1. Document a medical and/or non-medical exemption (A and/or B).
Place an X in the box to indicate a medical or non-medical exemption. If there are exemptions to more than one vaccine, mark each vaccine with an X.

Vaccine	Medical Exemption	Non-Medical Exemption
Diphtheria, Tetanus, and Pertussis		
Polio		
Measles, Mumps, Rubella		
Haemophilus influenzae type b		
Chickenpox (varicella)		
Pneumococcal		
Hepatitis A		
Hepatitis B		
Meningococcal		

A. Medical exemption: By my signature below, I confirm that this child should not receive the vaccines marked with an X in the table for medical reasons (contraindications) or because there is laboratory confirmation that they are already immune.

Signature: _____ Date: _____
(of health care practitioner*)

B. Non-medical exemption: A child is not required to have an immunization that is against their parent or guardian's beliefs. However, choosing not to vaccinate may put the health or life of your child or others they come in contact with at risk. Unvaccinated children who are exposed to a vaccine-preventable disease may be required to stay home from child care, school, and other activities in order to protect them and others.

By my signature, I confirm that this child will not receive the vaccines marked with an X in the table because of my beliefs. I understand that my child may be required to stay home from child care, school, and other activities if exposed.

Signature: _____ Date: _____
(of parent or guardian in presence of notary)

Non-medical exemptions must also be signed and stamped by a notary:

This document was acknowledged before me

on _____ (date)

by _____
(name of parent or guardian)

Notary Signature: _____

Notary Stamp

STATE OF MINNESOTA, COUNTY OF _____

2. History of chickenpox (varicella) disease. This child had chickenpox in the month and year _____

My signature below means that I confirm that this child does not need chickenpox vaccine because:

☐ I am a health care practitioner and this child was previously diagnosed with chickenpox or the parent provided a description that indicates this child had chickenpox in the past.

☐ I am the parent or guardian and this child had chickenpox on or before September 1, 2010.

Signature: _____ Date: _____
(of health care practitioner*, representative of a public clinic, or parent/guardian). Parent can sign if chickenpox occurred before September 2010.

*Health care practitioner is defined as a licensed physician, nurse practitioner, or physician assistant.

3. Consent to share immunization information: This school is asking for permission to share your child's immunization record with Minnesota's immunization information system. Giving your permission will:

- Provide easier access for you and your school to check immunization records, such as at school entry each year.
- Support your school in helping to protect students by knowing who may be vulnerable to disease based on their immunization record. This can be important during a disease outbreak.

Under Minnesota law, all the information you provide is private and can only be released to those authorized to receive it. Signing this section of the form is optional. If you choose not to sign, it will not affect the health or educational services your child receives.

I agree to allow my child's school to share my child's immunization documentation with Minnesota's immunization information system:

Signature: _____ Date: _____
(of parent/guardian)

PROVIDERS CHOICE

Annual Family CACFP Enrollment Form

Center Name: Nisse Treehouse LLC #237

Step 1 — List all children ages 0-17 years old living in your household, even if they are not related. If more space is needed, attach another sheet.

Child's First Name	Child's Last Name	Birthdate (mm/dd/yyyy)	Enrolled at this center?	In Foster Care?	Enrolled in Head Start?	Hours in Care: Arrive Time	Hours in Care: Leave Time	Varies	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Breakfast	AM Snack	Lunch	PM Snack	Dinner	EV Snack	Ethnicity*	Race**

(Normal Days in Care: Monday–Sunday; Normal Meals Received: Breakfast–EV Snack)

OPTIONAL TO COMPLETE – Ethnicity* *(Select one)* H: Hispanic or Latino N: Not Hispanic or Latino. Race** *(Select one or more)* B: Black or African American I: American Indian or Alaskan Native P: Native Hawaiian or other Pacific Islander A: Asian W: White

Step 2 — **Infants Under 12 Months Only:** The iron-fortified infant formula this center offers is: Up & Up Infant

☐ Parent/guardian accepts center formula ☐ Parent/guardian will provide breastmilk

☐ Parent/guardian declines center formula and will provide ______________ *(specify brand/type of iron-fortified infant formula)*

☐ Parent/guardian will provider more than 1 food item per meal/snack and decline the CACFP

Step 3 — If any household members currently participate in SNAP*, MFIP*, or FDPIR*, provide the case number. *If no, skip to step 4.* **SNAP** Case Number: **MFIP** Case Number: **FPIR** Case Number:

Step 4

Adult Income – List the full name and gross income (before taxes) for each adult household member (living with you, sharing income and expenses, related or not), including yourself. If any adult household members do not receive income from any source, write '0'.

Adult name	Gross Pay from Work (Do not write in an hourly wage): Gross pay before taxes (not take-home pay)	Weekly	Every 2 weeks	Twice per month	Monthly	Yearly	Farm or Self-Employment: Net Income after business expenses	Monthly	Yearly	Public Assistance, Child Support, Alimony: Payments received	Weekly	Every 2 weeks	Twice per month	Monthly	All other Incomes: Pension, retirement, disability, unemployment, Veterans benefits, etc.	Weekly	Every 2 weeks	Twice per month	Monthly
	$						$			$					$				
	$						$			$					$				
	$						$			$					$				

Child Income – Sometimes children in the household earn or receive income. Include the TOTAL income (before taxes) received by ALL children listed in STEP 1 here.

Total Income	Weekly	Every 2 weeks	Twice per month	Monthly	Yearly
$	☐	☐	☐	☐	☐

Step 5

I certify (promise) that all information provided is true and that all income is reported. I understand this information is given in connection with the receipt of Federal funds and officials may verify (confirm) the information. I am aware that I may be prosecuted under applicable State and Federal laws if I provide false information.

Print Name: Signature: Date (mm/dd/yyyy):

Last four numbers of signer's Social Security Number (SSN): or ☐ I do not have a Social Security Number *(Required if completing Step 4)*

Address (include street, city, state, zip code):

Phone: Email:

Sponsor Use Only—Do Not Write Here Effective Dates: From __________ TO __________ 1st Approval Signature: __________ Date: __________ 2nd Check Initials: ____

☐ Free (A)-Head Start ☐ Free (A)-Foster ☐ Free (A)-Case Number ☐ Free (A)-Income ☐ Reduced (B)-Income ☐ Paid (C) **Total Income:** $__________ How often: __________ HH Size: ____

If Children qualify differently – Head Start Child(ren): __________ Child(ren) in Foster Care: __________ Free/Reduced/Paid Child(ren): __________

Revised: 12-21-2022 Replaces: 07-08-2021

Tuition

ESB BANK
AUTHORIZATION AGREEMENT FOR ACH DEBIT TRANSACTIONS

I (we) hereby authorize ESB Bank to initiate **debit** entries to my (our) account the financial institution indicated below; and to **credit** the ESB Bank account listed below. I (we) agree to have available funds in my (our) account on the designated date to effect this transfer. I (we) agree to pay any applicable fees for this service as disclosed in the Fee Schedule. This authority will remain in effect until I (or either of us) notify the bank in writing at least 3 days prior to the next settlement date. I (we) acknowledge that the origination of ACH credit transactions from my (our) account must comply with the provisions of U.S. law.

Financial Institution Name (debit from)

Financial Institution Routing Number (debit from)

Type of Account: ☐ Checking ☐ Savings

Type of Transaction: ☐ Debit

Account Number (debit from)

Name(s) on Account (debit from)

VARIES
Amount of Debit Transfer

WEEKLY
Starting Date and Frequency of Debit Transfer*

*NOTE: If this date falls on a Saturday, Sunday, or bank holiday, this transfer will automatically be made on the following business day.

Type of Account: ☒ Checking ☐ Savings ☐ Loan

Type of Transaction: ☒ Credit ☐ Loan Payment

6129
Account Number (credit account with you)

NISSE TREEHOUSE LLC
Name(s) on Account (account with you)

ESB Bank will make every effort to complete this transfer unless circumstances beyond our control prevent the transfer, despite reasonable precautions that we have taken. All terms and conditions of your account agreement apply to this agreement.

I am an authorized signer (we are authorized signers), or otherwise have the authority to act, on the account identified in this authorization. I (we) understand that this authorization will remain in full force and effect until I (we) notify ESB Bank in writing that I (we) wish to revoke this authorization. I (we) understand that ESB Bank requires at least 3 days prior notice in order to cancel this authorization.

(Customer Printed Name) (Customer Signature) (Date)

I hereby authorize ESB Bank to cancel the above described automatic entry effective as of _____ (date).

(Customer Printed Name) (Customer Signature) (Date)

For Institutional Use Only:

Person taking ACH request: _____ Date: _____

Second person reviewing ACH setup: _____ Date: _____