

**Child Information**

[ ] Please Mark if Only Child Attending

First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name: \_\_\_\_\_

Name child prefers to be called: \_\_\_\_\_ Grade/Class: \_\_\_\_\_ Enrollment Date: \_\_\_\_\_

Child's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Gender: [ ] Male [ ] Female Date of Birth: \_\_\_\_\_

**Chronic Illnesses or Medical Conditions-**

Check all that apply:

Does your child have any known allergies or sensitivities to the following?

Medications [ ] Yes [ ] No If yes, please list: \_\_\_\_\_

Foods: [ ] Yes [ ] No If yes, please list: \_\_\_\_\_

Other: [ ] Yes [ ] No If yes, please list: \_\_\_\_\_

Does your child have any of the following?

Asthma [ ] Yes [ ] No Visual Impairment [ ] Yes [ ] No Headaches [ ] Yes [ ] No Seizures [ ] Yes [ ] No

Diabetes [ ] Yes [ ] No Chronic Ear Infections [ ] Yes [ ] No ADD/ADHD [ ] Yes [ ] No Hepatitis [ ] Yes [ ] No

Physical Impairment [ ] Yes [ ] No Developmental Delays [ ] Yes [ ] No Behavioral/Emotional [ ] Yes [ ] No

Heart Problems [ ] Yes [ ] No Hearing Impairment [ ] Yes [ ] No Stomach/Digestive [ ] Yes [ ] No

If you answered "yes" to any of the above questions, or if your child has any other health concerns, please give a brief explanation:

\_\_\_\_\_  
List any regular medications that child takes: \_\_\_\_\_

Will we need to administer during the hours that child attends? [ ] Yes [ ] No (If yes, please request a medication release form).

Any disorders/developmental (slow, advanced) diagnosed or suspected? \_\_\_\_\_

Please give a brief description of your child's disposition. Are they friendly by nature, aggressive, shy, withdrawn, imaginative, and/or demanding, etc. \_\_\_\_\_

Any problems with previous daycares: \_\_\_\_\_

\_\_\_\_\_  
Pediatrician's Name: \_\_\_\_\_ Date of last medical exam: \_\_\_\_\_

Address or Facility: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ Date of last dental exam: \_\_\_\_\_

Address or Facility: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

\_\_\_\_\_  
(Parent Signature) \_\_\_\_\_ (Printed Name) \_\_\_\_\_ (Date)

Reviewed and/or updated: ____/____/____	Parent/Guardian Signature: _____
Reviewed and/or updated: ____/____/____	Parent/Guardian Signature: _____
Reviewed and/or updated: ____/____/____	Parent/Guardian Signature: _____
Reviewed and/or updated: ____/____/____	Parent/Guardian Signature: _____
Reviewed and/or updated: ____/____/____	Parent/Guardian Signature: _____

**FAMILY REGISTRATION PARENT/GUARDIAN INFORMATION REGISTRATION DATE: \_\_\_\_\_**

**Primary Payer: Mother/ Father/Guardian (Circle One)**

First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
Home Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ May we contact you via text? [ ] Yes [ ] No  
Employer: \_\_\_\_\_ Work Hours: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_  
Email: \_\_\_\_\_ Would you like your monthly statements sent to this email? [ ] Yes [ ] No

*(Please note: By marking yes on the above option, you will not receive monthly statements via postal mail delivery.)*

This person may (or may not) be contacted for the following:

Emergencies- [ ] Okay To Contact [ ] Do Not Contact

Pick Up or Drop Off- [ ] Allow [ ] Do Not Allow *(Please note: a legal court document must be provided, before this can be enforced.)*

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed

**Secondary Payer: Mother/ Father/Guardian (Circle One)**

First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
Home Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ May we contact you via text? [ ] Yes [ ] No  
Employer: \_\_\_\_\_ Work Hours: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_  
Email: \_\_\_\_\_ Would you like your monthly statements sent to this email? [ ] Yes [ ] No

*(Please note: By marking yes on the above option, you will not receive monthly statements via postal mail delivery.)*

This person may (or may not) be contacted for the following:

Emergencies- [ ] Okay To Contact [ ] Do Not Contact

Pick Up or Drop Off- [ ] Allow [ ] Do Not Allow *(Please note: a legal court document must be provided, before this can be enforced.)*

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed

**Tuition / Payment Information:**

Do you currently receive or plan to apply for childcare assistance? [ ] Yes [ ] No If yes, which source: \_\_\_\_\_  
Please state if tuition is to be split and billed between both parents, in the space provided below. \_\_\_\_\_

*(Please Note: Each person responsible for payments must sign a tuition agreement in person.)*

Please do not list outside agencies, such as DWS (Child Care Subsidy) or any other assistance programs, in this section. We will gladly accept payments from other sources, however, only the person(s) signing the tuition agreement can and will be held responsible for payments due.  
\_\_\_\_\_  
\_\_\_\_\_

Is there any other information that would be helpful to our management and teaching staff? \_\_\_\_\_  
\_\_\_\_\_

**How did you hear about Little Wonders Learning Center?**

[ ] Drive By [ ] Word of Mouth [ ] Radio [ ] Newspaper [ ] Internet [ ] Phone Book [ ] Other: \_\_\_\_\_  
[ ] Referring Friend/Family Member. If so, whom may we thank? \_\_\_\_\_

**Emergency Contacts & Authorized Pickup Persons (other than parents):**

Contact/Pick Up Name: \_\_\_\_\_ Home /Cell Phone: \_\_\_\_\_  
Relationship to the Child: \_\_\_\_\_ Address: \_\_\_\_\_  
Please check all that apply: [ ] Emergency Contact [ ] Able to pick up all children in the family  
[ ] Not able to pick up the following children: \_\_\_\_\_

Contact/Pick Up Name: \_\_\_\_\_ Home /Cell Phone: \_\_\_\_\_  
Relationship to the Child: \_\_\_\_\_ Address: \_\_\_\_\_  
Please check all that apply: [ ] Emergency Contact [ ] Able to pick up all children in the family  
[ ] Not able to pick up the following children: \_\_\_\_\_

Contact/Pick Up Name: \_\_\_\_\_ Home /Cell Phone: \_\_\_\_\_  
Relationship to the Child: \_\_\_\_\_ Address: \_\_\_\_\_  
Please check all that apply: [ ] Emergency Contact [ ] Able to pick up all children in the family  
[ ] Not able to pick up the following children: \_\_\_\_\_

**Out of State Emergency Contact; Required by the State of Utah**

Name: \_\_\_\_\_ Home / Cell Phone: \_\_\_\_\_  
Relationship to the Child: \_\_\_\_\_ Address: \_\_\_\_\_  
[ ] Able to pick up all children in the family

**If you would like to add additional emergency contacts or authorized pickup persons, please request a second form to do so.**

We obtain strict confidentiality procedures at Little Wonders and take every effort to ensure that no one has unauthorized access to any child's personal information as well as that of their family. Information will not be disclosed to any unauthorized persons without written consent from you, the child's parent/guardian.  
We keep all records locked up and are made only accessible to our administration office. Any information that is given to us regarding your child and family will not be copied or shared with any other source, with the exception of an emergency situation (as stated in the section below).

**Signature Section:**

Please check one:  
[ ] YES [ ] NO I hereby give Little Wonders permission to photograph my child/children during daycare hours. I understand that photos may be used on our website [www.littlewondersteamingcenter.net](http://www.littlewondersteamingcenter.net) and for some social media and/or advertising purposes. Children's names and personal information will not be shared at any time. Parents will always be informed of when and how their child/children's picture(s) are being used. Photos will only be handled by management and with good taste and discretion.

Please check one:  
[ ] YES [ ] NO I hereby give Little Wonders permission to photograph my child/children during daycare hours. I understand that photos may be used on displays within the daycare such as my child's classroom or the office. Children's names and personal information will not be shared at any time. Parents will always be informed of when and how their child/children's picture(s) are being used. Photos will only be handled by management and with good taste and discretion.

Please initial:  
[ ] In case of emergency or serious illness, when parents cannot be reached immediately, I hereby authorize Little Wonders to obtain emergency medical care and/or provide emergency transportation for my child/children.

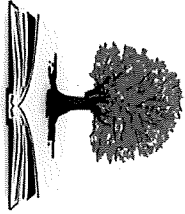
[ ] I acknowledge that I have received a copy of Little Wonders Policies. I have read it and agree to its conditions.

**By signing below, you agree that this is a legally binding form. Providing false information could result in termination of childcare services, forfeiture of retainer, or both.**

\_\_\_\_\_  
(Signature of Parent or Guardian)

\_\_\_\_\_  
(Printed Name)

\_\_\_\_\_  
(Date)



**Little Wonders**  
Where Children Learn, Develop, and Grow

## TUITION RATES

One-Time Registration Fee of \$50 (if continuously Enrolled)

\*No additional yearly fees

\*No drop-ins

All rates are for a **MONTHLY SLOT**

### PRESCHOOL 3 Hours/ Day Includes Lunch

9:30-12:30		9:00-12:00		9:00-12:00	
<b>Pre-Kinder (ages 4-5)</b>		<b>Little Learners (age 3)</b>		<b>Wee Wonders (age 2)</b>	
5 Days	\$330	5 Days	\$340	5 Days	\$380
4 Days	\$300	4 Days	\$310	4 Days	\$340
M / W / F	\$250	M / W / F	\$260	3 Days	\$310
Tu / Th	\$210	Tu / Th	\$220		

### CHILDCARE

Full Day: 10 Hours      Half Day: Up to 5.5 Hours      Includes Preschool, Breakfast, Lunch, and Snack

# Days	Kindergarten+		Age 3-5 <small>*must be potty trained</small>		Age 2		6 wks. - 24. mon.			
	Full	Half	Full	Half	Full	Half	# Days	Full		
5	*\$690	\$530	5	*\$820	\$630	5	*\$890	\$690	5	*\$1070
4	*\$630	\$490	4	*\$750	\$580	4	*\$780	\$600	4	*\$980
3	*\$510	\$430	3	*\$650	\$500	3	*\$680	\$520		
2	*\$450	\$360	2	*\$530	\$420	2	*\$570	\$450		

### BEFORE & AFTER SCHOOL PROGRAM

3 Hours/ Day Includes Breakfast &/or Snack

5 Days	\$400
4 Days	\$360
3 Days	\$320
2 Days	\$260

### TRANSPORTATION

One Way	\$85 / Month
Both Ways	\$150 / Month

### HOURLY RATES

Additional Fees when you go ABOVE Half Time, Preschool (3hrs), or B/A School (3hrs)

Wee Wonders	\$12
Little Learners	\$11
Pre-Kinder	\$10
Elementary	\$9

**Effective September 2024**

# TUITION CONTRACT

CHILD'S NAME \_\_\_\_\_

Effective Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## SCHEDULE

MONDAY \_\_\_\_\_ TUESDAY \_\_\_\_\_ WEDNESDAY \_\_\_\_\_ THURSDAY \_\_\_\_\_ FRIDAY \_\_\_\_\_

CHILD'S HOURS: Drop off \_\_\_\_\_ Pickup \_\_\_\_\_ TRANSPORTATION: 1 way \$85 \_\_\_\_ 2 way \$150 \_\_\_\_

MONTHLY TUITION \$ \_\_\_\_\_ HOURLY RATES\$ \_\_\_\_\_

This tuition agreement is Effective Starting September 1, 2024. Please fill out a new agreement if there is any change in your child's schedule during the year.

Tuition is due in advance on the 1<sup>st</sup> day of the month. Payment must be received prior to the 5th of each month to prevent a late fee assessment (\$25). If a balance remains on the 10th of the month your child will be suspended from care until the balance is paid in full. Finance charges in the amount of 18% per annum with a minimum of \$25 per month will be added to past due balances. A returned check fee or a credit card decline are assessed \$25. Tuition rates may be adjusted as needed throughout the year.

A non-refundable \$50.00 registration fee is due when turning in registration forms.

Monthly tuition is a set tuition with no allowances for holidays, scheduled closures, or absences including sickness and vacation. A child's slot may only be secured by continuous enrollment.

A two-week notice is required to withdraw children from Little Wonders. Tuition will continue to be billed until the required written notice of withdrawal is provided. Please fill out a "Child Withdrawal Form."

The Center closes at 6:00 pm. A late charge of \$5.00 for every 5 minutes will be assessed in addition to regular tuition if a child is not picked up by 6:00 pm.

Little Wonders Learning Center will be closed on the following dates during the 2024-2025:  
2024: Sept 2<sup>nd</sup>, Nov 28<sup>th</sup>-29<sup>th</sup>, Dec 24<sup>th</sup> & 25<sup>th</sup>, Dec 31<sup>st</sup>  
2025: Jan 1<sup>st</sup>, Jan 20<sup>th</sup>, Feb 17<sup>th</sup>, May 26<sup>th</sup>, July 4<sup>th</sup>, July 24<sup>th</sup>, Sept 1<sup>st</sup>, Nov 27<sup>th</sup> & Nov 28<sup>th</sup>, Dec 24<sup>th</sup> & 25<sup>th</sup> & 26<sup>th</sup>, Dec 31<sup>st</sup>

I agree to the terms and conditions set herein. If collections become necessary, I agree to pay all collection agency fees, court costs, and attorney fees up to 40%.

Date \_\_\_\_\_

Mother's Signature \_\_\_\_\_ Social Security # \_\_\_\_\_ Date \_\_\_\_\_

Father's Signature \_\_\_\_\_ Social Security # \_\_\_\_\_ Date \_\_\_\_\_

Administrator Signature \_\_\_\_\_

[For office use only] For updated Tuition Agreements:

- Billing Contract and Formula
- Prorate on Ledger
- Print Statement
- Infor to Transportation Dept.
- Child Tracking
- Child's Schedule
- Class List
- Preschool List
- Lunch Count
- Allergies
- Partnership Discounts (Initial Here if the partnership discount applies)
- Partnership: \_\_\_\_\_



What helps your child calm down? \_\_\_\_\_

When do you plan to introduce your child to solid food? (if applicable) \_\_\_\_\_

Does your child use a bottle/sippy cup? (circle one)                      YES                      NO

If "YES", would you like them to be weaned off? And when? \_\_\_\_\_

Something I LOVE about my child: \_\_\_\_\_

Something my child struggles with: \_\_\_\_\_

Health concerns we should be aware of: \_\_\_\_\_

Does your child have any allergies? \_\_\_\_\_

Are there any foods your child will NOT eat? \_\_\_\_\_

How does your child interact with other children? \_\_\_\_\_

Any special circumstances or additional information that Administration and Teachers should be aware of: \_\_\_\_\_

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**Getting To Know Your Child (2 Years and Older)**

**\*\*Please fill out ALL areas on this page\*\***

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parents/Guardians Names: \_\_\_\_\_

Parents/Guardians place of work and hours: \_\_\_\_\_

Does your child have siblings? (circle one):                      YES                      NO

If "yes", what are their names and ages? \_\_\_\_\_

\_\_\_\_\_

What is your family dynamic? (optional) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does your family have any pets? If yes, what kind are they and what are their names? \_\_\_\_\_

\_\_\_\_\_

What motivates your child? \_\_\_\_\_

\_\_\_\_\_

What are your child's likes: \_\_\_\_\_

What are your child's dislikes: \_\_\_\_\_

Typical mood/personality for your child: \_\_\_\_\_

\_\_\_\_\_

Social aspects you want your child to improve on: \_\_\_\_\_

\_\_\_\_\_

Educational aspects you want your child to improve on: \_\_\_\_\_

\_\_\_\_\_

What is your child's nap schedule/habits? \_\_\_\_\_

\_\_\_\_\_



How do you help your child when they are upset/not listening? \_\_\_\_\_  
\_\_\_\_\_

What helps your child calm down? \_\_\_\_\_  
\_\_\_\_\_

Something I LOVE about my child: \_\_\_\_\_  
\_\_\_\_\_

Something my child struggles with: \_\_\_\_\_  
\_\_\_\_\_

Is your child Potty Trained?                      YES                      NO

If "NO", are they in diapers or pull-ups? \_\_\_\_\_

What is your child's bathroom routines/habits at home? \_\_\_\_\_  
\_\_\_\_\_

Health concerns we should be aware of: \_\_\_\_\_  
\_\_\_\_\_

Does your child have any allergies? \_\_\_\_\_

Are there any foods your child will NOT eat? \_\_\_\_\_  
\_\_\_\_\_

How does your child interact with other children? \_\_\_\_\_  
\_\_\_\_\_

Any special circumstances or additional information that Administration and Teachers should be aware of: \_\_\_\_\_  
\_\_\_\_\_

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

# Tuition<sup>®</sup> Express

*Automated Payment Processing  
Safe – Convenient – Easy*

We are excited to offer the safety, convenience and ease of Tuition Express<sup>®</sup>—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

### ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) \_\_\_\_\_ to initiate credit card charges to the below-referenced credit card account (Section A) OR, initiate debit entries to my (our) checking or savings account, indicated below (Section B). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

#### COMPLETE ONE SECTION ONLY

##### SECTION A (Credit Card)

Cardholder Name \_\_\_\_\_

Phone # \_\_\_\_\_

Cardholder Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Account Number \_\_\_\_\_

Expiration Date \_\_\_\_\_

Cardholder Signature \_\_\_\_\_

Date \_\_\_\_\_

##### SECTION B (Bank Account)

Your Name \_\_\_\_\_

Phone # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Bank or Credit Union Name \_\_\_\_\_

Bank or Credit Union Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Routing Transit Number (see sample below) \_\_\_\_\_

Account Number (see sample below) \_\_\_\_\_

Checking

Savings

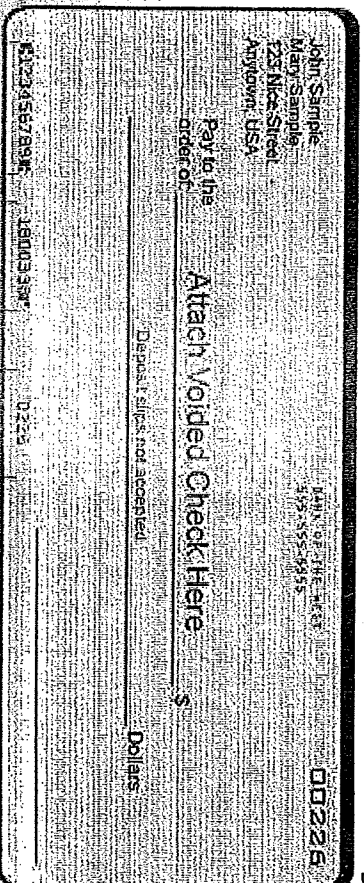
Authorized Signature \_\_\_\_\_

Date \_\_\_\_\_

#### For Official Use Only

Date Received \_\_\_\_\_

Employee Signature \_\_\_\_\_



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**PROCARE<sup>®</sup>**  
SOFTWARE





**INSTRUCTIONS**

Sources of Income

Sources of Income for Children

Sources of Income for Adults

Sources of Child Income	Example(s)	Earnings from work	Social Security	- Disability Payments	- Survivor's Benefits	- Income from person outside the household	- Income from any other source
- Earnings from work	- A child has a regular full or part-time job where they earn a salary or wages	- Salary, wages, cash bonuses	- A child is blind or disabled and receives Social Security benefits	- A Parent is disabled, retired, or deceased, and their child receives Social Security benefits	- A friend or extended family member regularly gives a child spending money	- A child receives regular income from a private pension fund, annuity, or trust	- Income from any other source

**OPTIONAL** Children's Racial and Ethnic Identities

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for free or reduced price meals

Ethnicity (check one):  Hispanic or Latino  Not hispanic or Latino  Asian  Black or African American  Native Hawaiian or Other Pacific Islander  White

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF-FEP) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

mail: U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW  
Washington, D.C. 20250-9410  
fax: (202) 690-7442; or  
email: program.intake@usda.gov

This institution is an equal opportunity provider.

**Do not fill out** For Official Use Only

Annual Income Conversion: Weekly x 52, Every 2 weeks x 26, Twice a month x 24, Monthly x 12

Total Income	<input type="text"/>	Household Size	<input type="text"/>	Categorical Eligibility	<input type="checkbox"/>	Free <input type="radio"/>	Reduced <input type="radio"/>	Paid <input type="radio"/>	Determining Official's Signature	<input type="text"/>	Date	<input type="text"/>
Weekly	<input type="radio"/>	Bi-Weekly	<input type="radio"/>	2x Month	<input type="radio"/>	Monthly	<input type="radio"/>	Verifying Official's Signature	<input type="text"/>	Date	<input type="text"/>	

## Food/Beverage Substitution Request Form

Name of Child	
Name of Parent or Guardian	Telephone Number
Food/Beverage to Omit	Food/Beverage to Substitute
Diagnosis:	
<p><b>Symptoms when food/beverage to be omitted is consumed:</b></p> <p><input type="checkbox"/> Not applicable, lifestyle or religious preference</p> <p><input type="checkbox"/> Nausea    <input type="checkbox"/> Vomiting    <input type="checkbox"/> Diarrhea    <input type="checkbox"/> Itching    <input type="checkbox"/> Swelling    <input type="checkbox"/> Rash    <input type="checkbox"/> Wheezing    <input type="checkbox"/> Coughing</p> <p><input type="checkbox"/> Choking    <input type="checkbox"/> Shortness of breath    <input type="checkbox"/> Other: _____</p> <p>Severity of symptoms:    <input type="checkbox"/> Mild    <input type="checkbox"/> Moderate    <input type="checkbox"/> Severe</p>	
General comments:	
<p><b>Check one:</b> This section must be completed by a <u>Licensed Physician</u>, refer to the reverse side of this page for definitions</p> <p><input type="checkbox"/> Child has a disability (requires the food/beverage substitution be followed by the caregiver)</p> <p><input type="checkbox"/> Child does not have a disability (does not require the food/beverage substitution to be followed by the caregiver, but is requested)</p>	
Signature of medical authority and title	
Telephone Number	Date
<p>I give permission for the institution's personnel responsible for implementing my child's prescribed diet order to discuss my child's special dietary accommodations with any appropriate institution staff and to follow the prescribed diet order for my child's meals. I also give permission for my child's medical authority to further clarify the prescribed diet order on this form if requested to do so by institution personnel.</p>	
Signature of parent or guardian:	



## Child Care Waiver of Liability

Child's Last Name \_\_\_\_\_

Child's First Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

### Parents/Legal Guardian

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Email \_\_\_\_\_

Driver's License Number and State \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_

Emergency Contact Number \_\_\_\_\_

### Signature of Parent/Guardian:

\_\_\_\_\_

Waiver of Liability, and Assumption of Risk & Indemnity Agreement Notice: This is a legal binding agreement. I understand that by signing this Childcare Waiver of Liability, I release and hold harmless Little Wonders Learning Center and its owner, directors, office managers, caregivers, and all other persons acting for them, from any and all claims, demands, suits, cost and charges, in connection with Little Wonders Learning Center Inc., including but not limited to; personal injury, bodily harm, injury or property damage occurring while the above child / children is/are in their care at Little Wonders Learning Center.

Child and Adult Care Food Program  
**INFANT FORMULA/FOOD WAIVER NOTIFICATION**

Little Wonders Learning Center  
(Name of Child Care Center/Home)

(Infant's Name)

(Birth Date)

**For Parent/Guardian of Infants Age Birth Through 11 Months**

This child care center/home participates in the Child and Adult Care Food Program (CACFP) and is required to follow the Infant Meal Pattern for infants ages birth through 11 months. Solid foods are introduced to infants when developmentally ready, a decision made by you and your infant's doctor. To better meet your personal preferences and your infant's needs, please complete this document.

*(Instructions—The center/home must complete this section before giving to the parent/guardian.)*

**This center/home will provide:**

Iron-fortified infant formula (list brand) WOMEN'S WAY & WOMEN'S MILK SENSITIVE

Iron-fortified infant cereal (list type such as baby rice cereal) VALLEY VINE CEREAL; and

Food appropriate for infants  Commercial baby food and/or  Table food offered at the appropriate consistency for the development of the infant

*(Instructions—The parent/guardian must ANSWER THE FOLLOWING QUESTION and MARK ONE OF THE CHOICES FROM EACH OF THE THREE SECTIONS BELOW; then sign and date this form.*

**What do you currently feed your infant?**

- Iron-fortified infant formula
- Breast milk
- Low-iron or another type of infant formula provided for medical reasons  
I will receive a *Medical Exception Statement for Food Substitutions.*

**The parent or guardian would like their infant to be fed the following while in care.**

**Section 1—Infant Formula or Breast Milk**

Choice 1— I want my infant to receive the child care center-/home-provided iron-fortified infant formula identified above. I will not bring infant formula from home.

Choice 2— I understand I am not required to bring infant formula that I purchase or receive from Women, infants, and Children (WIC), however, I want to bring my own formula/breast milk. If I should forget to bring infant formula/breast milk, the child care center/home will contact me immediately and I may request they serve my infant the center-/home-provided iron-fortified infant formula that day.

**Section 2—Infant Cereal**

Choice 1— I want my infant to receive the child care center-/home-provided iron-fortified infant cereal, identified above. I will not bring infant cereal from home.

Choice 2— I understand I am not required to bring iron-fortified infant cereal that I purchase or receive from WIC, however, I want to bring my own infant cereal. If I should forget to bring the cereal, the child care center/home will contact me immediately and I may request they serve my infant the center-/home-provided iron-fortified infant cereal that day.

**Section 3—Baby Food**

Choice 1— I want my infant to receive the child care center-/home-provided baby food identified above. I will not bring baby food from home

Choice 2— I understand I am not required to bring baby food that I purchase, however, I want to bring my own baby food. If I should forget to bring the baby food, the child care center/home will contact me immediately and I may request they serve my infant the center-/home-provided baby food that day.

If I decide to change the selections I made above, I will be required to complete another form.

(Parent's Signature)

(Date)

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue S.W., Washington, D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6982 (TTY). USDA is an equal opportunity provider and employer.

## Infant Feeding Plan

\*A written plan shall be maintained on file and available for the caregiver of any child less than 12 months of age.

Child's Name \_\_\_\_\_ Date \_\_\_\_\_

Child's Birthdate \_\_\_\_\_

Formula:	Yes / No	Breast Feeding/ Breastmilk:	Yes / No
Yes / No	Will formula be prepared at home?	<input type="checkbox"/> I will nurse my child at the center at these times:	
Yes / No	Will formula be prepared by caregiver?	<input type="checkbox"/> I will provide breastmilk	
If the caregiver will be preparing the formula, please indicate any special instructions:		If breast milk is unavailable for a feeding, the center should: _____	
_____		_____	

\*All breastmilk must be labeled with child's name and date

### Feedings:

Please describe your child's feeding schedule, including amount given:

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Yes / No      Does your child take a bottle?  
 Yes / No      Is the bottle warmed?  
 Yes / No      Does your child hold his/her own bottle?  
 Yes / No      Are there any special instructions for bottle feeding your child?  
 If "yes", please explain: \_\_\_\_\_

Yes / No      Does your child have any problems with feedings, such as choking or spitting up?  
 If "yes", please explain: \_\_\_\_\_

### Introduction to solid foods:

The introduction of solid foods should occur no sooner than 4 months. Please consult with your child's primary physician before giving solid foods.

Yes / No      Has your child started eating solid foods?  
 If "yes", what type of food are they being offered:  
 Semisolid foods (Infant Cereal, strained fruits/vegetables)  
 Modified table food (mashed, soft, or diced fruit/vegetables, strained meats, pieces of soft bread)  
 Finger foods (Small pieces of soft/ cooked table food, chopped food)

Please describe your child's solid food schedule:  
 \_\_\_\_\_  
 \_\_\_\_\_

If "no", when do you plan to introduce solid foods? \_\_\_\_\_

### Updates:

Date:	Changes to feeding plan:	Parent initials:



## LITTLE WONDERS TRANSPORTATION POLICIES

We are excited to start another school year, and we want to be sure that our routes run smoothly and safely. Please read through the following guidelines, and let us know if you have any questions or concerns.

Unless you notify Little Wonders one hour in advance, we will assume that we are taking and/or picking up every child on the schedule, and you will be charged. If your child is sick or won't be attending school for any reason, please call by 7:30 am and leave a message, specifying which trips you are canceling.

Any behavior that endangers your child or others, distracts the driver, or delays the bus, will result in a warning the first time, a phone call to the parents the second time, and a two week suspension from the bus the third time.

Examples of these behaviors include: taking seat belts off or refusing to put them on, screaming, hitting, refusing to get on the bus, or not meeting in the designated area on time.

If we cannot find your child within five minutes of the school's dismissal time, we will attempt to call you. After 10 minutes total, we must leave in order to get to the next school. We will not be able to return to the school once the child is found. Please communicate with your child about what to expect every day.

Little Wonders cannot be responsible for children left at school because of miscommunication from parents or because a child could not be found.

We do everything we can to keep up on the school schedules, but it is the parent's responsibility to let us know of any schedule changes.

Because most schools begin and end at the same time, your child may be dropped off fifteen minutes before school and picked up fifteen minutes after. We will make arrangements with the office if this becomes necessary.

We have your child scheduled on the following route(s):

Name of Child: \_\_\_\_\_

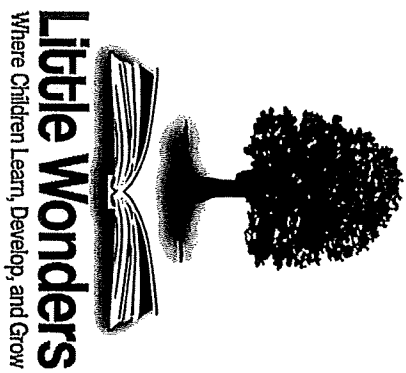
School child attends: \_\_\_\_\_

A.M. DROP OFF TIME: \_\_\_\_\_ A.M. PICK UP TIME: \_\_\_\_\_ P.M. PICK UP TIME: \_\_\_\_\_

Days of the Week: \_\_\_\_\_

*I have read and agree with Little Wonders Transportation Policies.*

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_



Dear Parents or Guardians,

We are creating a new text messaging system for parents and families to receive messages from our Center. For the new messaging system we need parent or guardian service carriers listed on our portal, for our portal to correctly send messages based on service carrier preferences. The messages that will be sent will include: Center Events, fire drills, emergency information, holiday closures, etc. Please fill out the form at the bottom of this page and return to the office or your child's teacher by April 5<sup>th</sup>, 2024.

Thank you,

*Srinoy Menjivar*

Director Little Wonders Learning Center South

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

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

Child's name: \_\_\_\_\_

Would you like to receive text messages: Yes

No

Phone Service Carrier: \_\_\_\_\_

\*Message and data rates may apply