CHILDREN'S RECORD
Nebraska Health and Human Services System

PARENTS: PLEASE FILL IN ALL BLANKS

Child(ren)'s Name: ______________________ Birthdate(s): ______________________

Enrollment Date: ______________________ Last Enrollment Date: ______________________

Parent or Guardian's Home Address and Employment Address:

FATHER (or Guardian):

Name: ______________________ Employer: ______________________

Address: ______________________ Address: ______________________

City: ____________ Phone: ____________ City: ____________ Phone: ____________

MOTHER (or Guardian):

Name: ______________________ Employer: ______________________

Address: ______________________ Address: ______________________

City: ____________ Phone: ____________ City: ____________ Phone: ____________

Person(s) to Whom the Child(ren) may be Released by the Caregiver: (If no one, please write "none")

Name: ______________________ Name: ______________________

Address: ______________________ Address: ______________________

City: ____________ Phone: ____________ City: ____________ Phone: ____________

Person(s) Who Will Take Responsibility for the Child(ren) in an Emergency When the Parent (or Guardian) Cannot be Reached: (ONE NAME MUST BE GIVEN)

Name: ______________________ Name: ______________________

Address: ______________________ Address: ______________________

City: ____________ Phone: ____________ City: ____________ Phone: ____________

Consent to Contact Physician in Emergency:

In the event I cannot be reached to make arrangements, I hereby give my consent to ______________________
Caregiver

to contact Doctor ______________________ ______________________
Name of Physician Phone

______________________ and, if necessary, take my child(ren) to the
Address City

following doctor(s), clinics, or hospital ______________________

______________________ ______________________
Signature of Parent/Guardian Date

Transportation Permission

I hereby give ______________________ permission to transport or
Name of Facility

arrange for transportation of my child ______________________
Name of Child(ren)

I understand staff will insure that my child(ren) is placed in the appropriate safety restraint as indicated by Nebraska law at all times the vehicle is in motion.

______________________ ______________________
Signature of Parent/Guardian Date

printed on recycled paper

Medication Competency Statement

I, ______________________________ have determined
Parent /Guardian Name

______________________________ competent to give or apply medication to my child(ren).
Provider/Director

______________________________ ______________
Signature of Parent/Guardian Date

CHILD'S MEDICAL INFORMATION

Any health problems which caregiver should know: ______________________________

Medication, if any: ______________________________

Allergies, if any: ______________________________

Special Concerns: (Glasses, Hearing Aid, Crutches) ______________________________

Any activities child(ren) should NOT engage in: ______________________________

Company providing health and/or accident insurance coverage: (Optional) ______________________________

Certificate of Immunizations

VACCINE	TYPE OF VACCINE	Dose	Normal Schedule	Date Given Mo.	Day	Yr.	DOCTOR OR CLINIC ADMINISTERING
Polio OPV or IPV		1	2 mo.				
		2	4 mo.				
		3	6-18 mo.				
		4	4-6 yrs.				
DTP/DT/DTaP Diphtheria Tetanus Pertussis		1	2 mo.				
		2	4 mo.				
		3	6 mo.				
		4	15-18 mo.				
		5	4-6 yrs.				
Tdap		1	11-18 yrs.				
Td/Tetanus and Diphtheria							
Hib Haemophilus influenzae b		1	2 mo.				
		2	4 mo.				
		3	6 mo.				
		4	12-15 mo.				
M-M-R		1	12-15 mo.				
		2					
Hepatitis A		1					
		2					
Hepatitis B		1					
		2					
		3					
Varicella Chickenpox		1	12-18 mo.				
		2					
date of disease							
Meningococcal Conjugate		1					
PCV Pneumococcal Conjugate		1	2 mo.				
		2	4 mo.				
		3	6 mo.				
		4	12-15 mo.				
Rotavirus		1	2 mo.				
		2	4 mo.				
		3	6 mo.				

I certify that the above information is correct to the best of my knowledge.

______________________________ ______________
Signature of Parent/Guardian or Physician Date

NFC Early Learning Center Enrollment Form

CHILD INFORMATION

CHILD'S FIRST AND LAST NAME:____

MEDICAL INFORMATION/SPECIAL REQUESTS (IMPORTANT & REQUIRED): List any medical conditions, allergies to food/medications, special diets or any conditions that may affect your child's health while in the program.

____

____

____

____

PERSONALITY & DEVELOPMENT INFORMATION (IMPORTANT & REQUIRED): Please describe your child's personality and information you feel would be helpful to his/her teacher including potty-training, behavior concerns, likes/dislikes, goals, etc.

____

____

____

____

____

PERMISSION FORM

☐YES ☐NO I give staff permission to use photographs for promotional materials.

☐YES ☐NO I give staff permission to transport my child for the purpose of program activities.

☐YES ☐NO I give permission for the NFC lead agency to arrange for emergency treatment and to contact our family health care provider if guardian is unable to be reached and it is necessary to preserve the health of my child(ren) until such time then I/we can be present. I understand that no guarantees have been made to me as to the effect of such treatment on my child's condition. If necessary, the program will arrange for emergency transportation to the nearest emergency medical facility.

By signing below I give permission for my child to participate in program activities. I understand that the NFC does not carry health and accident insurance for my child/youth, and that I as guardian will be primarily responsible in case of injury where bills are incurred. As the parent/guardian, I will work as a partner with staff to ensure my child is successful in the program. I understand that my child may be dismissed for failure to follow rules, failure to follow general operating procedures of the program. The information I have listed is correct to the best of my knowledge and I will notify the program staff of any changes to the information in a timely manner. **I have read The NFC Early Learning Center Parent Handbook and agree to the program policies.**

_______________________________________ ______________

SIGNATURE OF PARENT OR GUARDIAN **DATE**

PAYMENT AGREEMENT

A $30/child or $50/family non-refundable enrollment fee is due at the time of registration.

Please select your payment option for the program:

- ☐ Weekly – Infants:$158
- ☐ Weekly - Toddler: $143
- ☐ Part-Time Toddler: $71.50
- ☐ Weekly - Preschooler: $133
- ☐ Part-Time Preschooler: $66.50
- ☐ Weekly – School Age $120
- ☐ Auto-Debit - When selecting this option you will be provided with a form authorizing NFC to make an automatic debit payment either weekly or bi-weekly for your tuition payment.
- ☐ Title XX - Caseworker:_______________________Phone:_______________
  *Please note that authorization must be received by NFC from caseworker **prior** to child's start date.

I understand that payment is due prior to my child receiving care at the NFC Early Learning Center. If my child receives Title XX funding, I understand that there will be a set daily fee charged to me for absent days. I further understand that there is a late-pick up fee of $15 for the first 5 minutes after 6:00PM and $1.00 for each minute thereafter that will be added to my account.

______________________________ ______________

SIGNATURE OF PARENT OR GUARDIAN **DATE**

FOR OFFICE USE ONLY:

Date Processed:__________________ Staff:_______________________________

Enrollment Fee Paid:______________ Planned Start Date:____________________

NFC Client Demographic Information

We request your cooperation in completing the following voluntary demographic information. This information will not be used in making any decision affecting your enrollment in any agency program(s). It will be used to complete records required of NFC by governmental authorities, United Way &/or other grant funding.

Please Complete for ALL members of the family currently residing in the household.

TOTAL NUMBER IN HOUSEHOLD:________

AGE (please list number of family members in each category):

(_____) birth-5 (_____) 5-12 (_____) 13-18 (_____) 18-30 (_____) 30-60 (_____) 60-over

GENDER (please list number of family members in each category):

(_____) MALE (_____) FEMALE

ETHNICITY (please list number of family members in each category):

(_____) HISPANIC/LATINO (_____) OTHER (NON-HISPANIC/LATINO)

RACE (please list number of family members in each category):

(_____) ASIAN (_____) BLACK OR AFRICAN AMERICAN
(_____) AMERICAN INDIAN OR ALASKAN NATIVE (_____) NATIVE HAWAIIAN OR PACIFIC ISLANDERS
(_____) WHITE (_____) OTHER
(_____) OTHER MULTI-RACIAL

Do any members of the household have a physical or mental disability? ( ) Yes ( ) No

*If yes, please explain:*____

____

HHS POVERTY GUIDELINES

Does your family fall at or below the federal poverty guidelines?

(_____) YES (_____) NO

Persons in Family or Household	48 Contiguous States and D.C.
1	$10,210
2	13,690
3	17,170
4	20,650
5	24,130
6	27,610
7	31,090
8	34,570
For each additional person, add	3,480