OMEGA'S DREAM

CHILD CARE

Parent Enrollment and Child Care Consent Forms

8501 Colonel Glenn Road Little Rock, AR 72204
(501) 499-9902
dnavarro@omegasdream.com
www.omegasdream.com

Director: Darlisa Navarro
Owner: Darlisa Navarro

Child's Name:	
Child's Birthday:	
Child's Age:	

Current Address:

_____

PARENT / GUARDIAN INFORMATION

Parent/Guardian's Name:

_____

Parent/Guardian's Name:

_____

Parent/Guardian Information

Parent/Guardian Home Phone:	
Parent/Guardian Work Phone:	
Parent/Guardian Cell Phone:	

Parent/Guardian Information

Parent/Guardian Home Phone:	
Parent/Guardian Work Phone:	
Parent/Guardian Cell Phone:	

Emergency Contact Information

Emergency Contact Person:	
Contact's Phone:	
Emergency Contact Person:	
Contact's Phone:	

ENROLLMENT SCHEDULE

Start Date:

_____

Hours:

DAY	START TIME	END TIME
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

Estimated time of drop-off:	
Estimated time of pick-up:	

ABOUT YOUR CHILD

What type (center, family daycare, home care): _____

Was it a positive experience?

_____

_____

Why are you looking for childcare?

_____

_____

How does your child feel about daycare and being left by his/her mommy/daddy?

_____

_____

Are there any recent traumatic situations the child has been exposed to such as a death in the family, divorce, new sibling etc.?

_____

_____

What is your normal method of discipline?

_____

_____

What is your child's temperament? Are they easy-going, hard to please, demanding, aggressive?

_____

_____

Are there any food restrictions?

_____

_____

What is your child's favorite food?

_____

_____

What food does your child dislike?

_____

_____

Can your child be relied upon to indicate bathroom wishes?

_____

What words does your child use for:

Bowel movements? _____

Urination: _____

What time does your child wake up?

_____

What time does your child go to sleep at night?

_____

Do they sleep through the night?

_____

Does your child sleep in a bed or crib?

_____

Are there any siblings? Please name them and specify ages and gender.

Name:	Age:	Gender:
Name:	Age:	Gender:
Name:	Age:	Gender:
Name:	Age:	Gender:
Name:	Age:	Gender:
Name:	Age:	Gender:
Name:	Age:	Gender:

Has your child had experience playing with other children?

_____

_____

What language(s) are spoken at home?

_____

_____

Does your child have any security objects such as a blanket, soother, bottle, toy etc.?

_____

_____

What are your child's favorite activities, toys, books, or games?

_____

_____

Are there any other comments or information you would like to let me know about?

_____

_____

Parent/Guardian Signature **Date**

Parent/Guardian Signature **Date**

MEDICAL INFORMATION AND CONSENT

Child's Name:

- ☐ I confirm that my child is up to date on their immunizations.
- ☐ I have attached a copy of my child's immunization and health records.

EMERGENCY CONTACT INFORMATION OF GUARDIANS/PARENT		
1. Name:	Relationship:	Phone:
Work Phone:	Work Address:	
2. Name:	Relationship:	Phone:
Work Phone:	Work Address:	
3. Name:	Relationship:	Phone:
Work Phone:	Work Address:	

INFORMATION ON CHILD'S DOCTOR	
Name:	Phone:
Address:	Hours:
INFORMATION ON CHILD'S DENTIST	
Name:	Phone:
Address:	Hours:
INSURANCE INFORMATION	
Name:	Phone:
Address:	Hours:

Does your child have any known allergies?

_____

_____

Are you concerned that your child may be prone to any type of allergies?

Describe:

_____

_____

Does your child have any medical conditions which I should be made aware of?

_____

Has your child had the following common childhood illnesses?

(*Please circle*)

Does your child have any problems with any of these?	Has your child had any of these diseases?
Constipation	Asthma
Convulsions	Bronchitis
Diarrhea	Chicken Pox
Fainting Spells	Diabetes
Frequent Colds	Heart Disease
Frequent Ear Infections	Hepatitis
Frequent Sore Throats	Impetigo
Lice	Measles
Ringworm	Mumps
Skin Rash	German Measles
Soiling	Polio
Stomach Upsets	Scarlet Fever
Urinary Problem	Tuberculosis
Worms	Whooping Cough

Does your child have any speech, hearing, or visual problems?

_____

_____

Does your child wear glasses or contacts?

_____

_____

Would there be any restrictions to play or activities?

_____

_____

EMERGENCY TREATMENT AND TRANSPORTATION

I hereby give permission to Omega's Dream Child Care, LLC to secure emergency medical and or dental treatment and to provide emergency transportation for the above-named minor child while in care. Non-emergency medical treatment is not included in this authorization.

Signature of Parent/Guardian: _____

Date: _____

EMERGENCY INFORMATION

Hospital:	Address: Phone:
Poison Control:	Address: Phone:
Fire Department:	Address: Phone:
Police Department:	Address: Phone:

MEDICAL LIABILITY

CHILD'S FULL NAME	
PARENT #1 FULL NAME	
PARENT #2 FULL NAME	

We, _____, the parents of _____, sign and agree to the following:

We understand and agree to a full and complete waiver and liability release on the part of Omega's Dream Child Care, LLC in connection with my child's enrollment at the school. This includes my child's participation in all activities, including but not limited to, the playground, field trips, classroom activities, and walks in the neighborhood. I understand and agree that this liability release will apply to my child's entire attendance at Omega's Dream Child Care, LLC and participation in all the school's activities.

We authorize anyone working at the school to obtain medical care for my child and to transport my child to a hospital if in the workers opinion that medical care for my child is needed. We agree to pay all costs associated with the medical care including transportation, medical care, medication, and any other costs associated. We understand and agree that the school and its employees are not responsible for any costs incurred.

We acknowledge that we have carefully read this form and understand and comply with all contents.

_____ _____

Parent Signature **Date**

_____ _____

Parent Signature **Date**

_____ _____

Administration Signature **Date**

GUARDIAN/PARENT AND THE CHILD'S DOCTOR MUST COMPLETE THIS FORM IF THE STUDENT HAS FOOD ALLERGY AND ANAPHYLAXIS EMERGENCY CARE PLAN

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergic to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

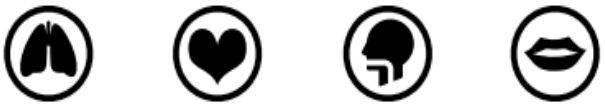
THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS



LUNG Shortness of breath, wheezing, repetitive cough

HEART Pale or bluish skin, faintness, weak pulse, dizziness

THROAT Tight or hoarse throat, trouble breathing or swallowing

MOUTH Significant swelling of the tongue or lips

SKIN Many hives over body, widespread redness

GUT Repetitive vomiting, severe diarrhea

OTHER Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE Itchy or runny nose, sneezing

MOUTH Itchy mouth

SKIN A few hives, mild itch

GUT Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

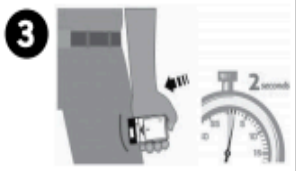
_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FARE Food Allergy Research & Education

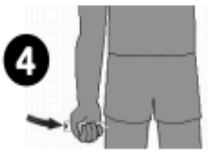
FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO



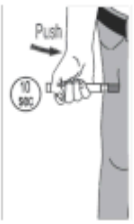
1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.

HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN



1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS



1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

GUARDIAN/PARENT AND THE CHILD'S DOCTOR MUST COMPLETE THIS FORM IF THE STUDENT HAS AND ASTHMA ACTION PLAN

Asthma Action Plan

Personal best peak flow: _____

IMPORTANT INFO

Name: _____

Date: _____

Doctor name: _____

Doctor phone: _____

Emergency contact: _____

Emergency phone: _____

EXERCISE-INDUCED FLARE-UP

Instructions for an exercise-induced asthma flare-up

Medicine: _____

How much: _____

When: _____

Additional instructions: _____

TRIGGERS: ☐ pollen ☐ mold ☐ dust mites ☐ animals ☐ smoke ☐ food ☐ exercise ☐ cold/flu ☐ weather ☐ air pollution ☐ other _____

The GREEN Zone (also known as the safety zone)

Symptoms

- Breathing is easy
- No cough or wheeze
- Can do usual activities
- Can sleep through the night

Peak flow from ____ to ____

Use these long-term control medicines as listed:

Medicine	How much	How often / when

The YELLOW Zone (also known as the caution zone)

Symptoms

- Some shortness of breath
- Cough, wheeze, or chest tightness
- Some difficulty doing usual activities
- Sleep disturbed by symptoms
- Symptoms of a cold or flu

Peak flow from ____ to ____

Continue with long-term control medicines as above, and add these quick-relief medicines:

Medicine	How much	How often / when

Call your doctor if: _____

The RED Zone (also known as the danger zone)

Symptoms

- Severe breathing problems
- Cannot do usual activities
- Difficulty walking and talking
- Rescue medicine is not helping

Peak flow from ____ to ____

Take this medicine and call the doctor now!

Medicine	How much	How often / when

If symptoms don't improve and you can't contact the doctor, go to the hospital or call 911.

PRESCRIPTION MEDICATION PERMISSION FORM AND MEDICATION LOG

Child's Name:

Date:

I give permission to my childcare provider, _____, to administer the following medication to my child. I will not hold my provider liable in the event of reactions or complications arising from my child receiving this medication.

Parent Signature _____

Name of Medication: _____

Reason for Medication: _____

Start Date _____ Finish Date _____

Times for each dosage: _____ am or pm _____ am or pm

Amount per dose: _____

Dosage Log

Date	Time	Dose	Signature	Comments

APPLICATION OF NON-MEDICATED TOPICAL PRODUCTS

We _____, parents of_____, authorize Omega's Dream Child Care, LLC staff to apply the following non-medicated topical cream/lotion to our child. We have applied this product to our child at least once before, and our child has no known allergies to it. This cream will be in its original container and labeled with our child's name. This cream will not be used or shared with other student's than the one approved on this consent form. Parent's and Guardian's will be notified when the product is close to being completely used and the school needs a refill.

If a parent or guardian would like the school to use a different brand than listed on this form, they must complete a new application of topical non-medicated product consent form.

Non-Medicated Product	Name/Brand	How Often Applied
Diaper Rash Cream		
Cream/Lotion for Dry Skin		
Lip Balm		
Sunscreen		

_____ _____

Parent Signature/Guardian Signature **Date**

_____ _____

Parent Signature/Guardian Signature **Date**

PICK UP AUTHORIZATION

Name of Child(ren):_____

I hereby inform Omega's Dream Child Care, LLC that the people listed below are authorized to pick up the above-named child(ren) at any time.

AUTHORIZED PICK-UP PERSON:

Name	Relation to Child	Phone Number

I understand that:

- Parents/guardians must inform Omega's Dream Child Care, LLC through phone call, note or conversation at drop off to an employee, of the name of the person who will be authorized to pick up the child.
- The "Authorized Pick-Up Person" **must be at least 18 years old** and may be asked to show photo ID to an employee.
- This authorization shall remain in force until edited or rescinded in writing.

_____ _____

Parent Signature/Guardian Signature **Date**

_____ _____

Parent Signature/Guardian Signature **Date**

LATE PICK-UP ACKNOWLEDGMENT

Omega's Dream Child Care, LLC understands that there are times where traffic can be unpredictable, and things may come up which will make a parent/guardian late to pick up their child. However, we kindly request that every effort is made to pick up your child at 6:00 pm

If a parent or guardian is late, we request a call informing the school, but please know this does not excuse the late pick-up charge.

Omega's Dream Child Care, LLC charges a $50.00 late fee per child after 6:01 and one dollar per minute until child is picked up. Late fees are due at the time of pick-up or before the child/ren returned to the center.

The child's pick-up time and the fee will be documented by staff on the sign-in/sign-out sheet. The time documented will be based on the exact time parent or authorized pick-up people leave the school after 6:00 pm

The total fee(s) will be deducted as part of your child's monthly tuition.

The school will take the following steps if the employee has not heard from the child's parent or guardian 20 minutes after the school has closed:

1. **The employee will attempt to reach the guardians or parents at home or at their place of work.**
2. **The employee will then attempt to reach the people listed on the student's authorization to pick up the form, and from the student's emergency contact information form.**
3. **The employee will call the authorities and notify them of the situation.**

It is the responsibility of the parent/guardian to have a plan for emergency pick-ups for their child. Parents who are consistently late may jeopardize their child's enrollment in the program.

_____ _____

Parent Signature/Guardian Signature **Date**

_____ _____

Parent Signature/Guardian Signature **Date**

MULTIMEDIA CONSENT FORM

I give my consent forOmega's Dream Child Care, LLC to photograph or video my child and/or me or use photograph(s) or videos that already exist of my child and/or me that were taken in a childcare setting. I understand that the photographs, digital images, or video segments may be used in print or electronic media and that the photographs may be displayed on the school's website, or social media pages. I give Omega's Dream Child Care, LLCpermission to publish, exhibit, and distribute these materials. I understand that Omega's Dream Child Care, LLC owns the copyright to the multimedia material in which I, or my child may appear. Omega's Dream Child Care, LLC will assure that it conveys positive images of children and reflect early childhood recommended practice.

If a parent/guardian decides to take back an authorization letter, the parent/guardian may do so by completing this form.

For protection of the privacy of the child, we guarantee that names will not be included.

Permission for Minor	**Permission for Minor**
Name of Child: _____	Name of Child: _____
Parent/Guardian Signature_____	Parent/Guardian Signature_____
Date: _____	Date: _____

☐ **We the parents/guardians of _____ DO NOT GIVE permission.**

_____ _____

Parent Signature/Guardian Signature **Date**

_____ _____

Parent Signature/Guardian Signature **Date**

PUBLIC PARKS AND FIELD TRIP PERMISSION FORM

We authorize Omega's Dream Child Care, LLC to take our child to nearby public park facilities, on walking trips in the neighborhood and special field trips. We also authorize our child to ride as a passenger on a school bus provided by a licensed school transportation company, beginning when our child is in the Toddler I classroom, or is one year old. We understand all such trips are under the supervision of the staff of Omega's Dream Child Care, LLC and that all precautions are taken in compliance with standards during such trips.

We recognize that if we choose not to send our child on a field trip, we must provide alternate care for the duration of the trip. We understand that Omega's Dream Child Care, LLC will not offer tuition reimbursement or alternate care.

Omega's Dream Child Care, LLC uses the Western Hills Park located at 5207 Western Hills Ave, Little Rock, AR 72204 for the students outside play time.

Parent Signature/Guardian Signature	**Date**
Parent Signature/Guardian Signature	**Date**

TUITION AGREEMENT

- I agree to promptly notify the school of any changes of the above information.

Starting Month:							
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Payment Information:							
Fee: per: Hour Day Week Month				Date payment due: Source of payment: Parent Other (specify):			
Overtime rate: per				Late fee: per			
Student's Name:							
Parent/guardian name:							
Parent/guardian name:							

- I understand that I am responsible for the terms of this agreement.
- I understand and comply with all policies and procedures of Omega's Dream Child Care, LLC

Parent Signature/Guardian Signature **Date**

Parent Signature/Guardian Signature **Date**

SUMMARY OF LICENSING RECEIPT HANDBOOK

Today's Date:

- We _____ the parents of _____have received a copy of the State of Arkansas
- I agree and understand the policies and procedures provided by the state.
- I am aware that Omega's Dream Child Care, LLC is governed by the State of Arkansas SERT LICENSING BODY, and the school must follow all state and federal laws.
- I understand I will be made aware of these changes in a timely fashion, and I will always adhere to the most up to handbook.

_____ _____

Parent Signature/Guardian Signature **Date**

_____ _____

Parent Signature/Guardian Signature **Date**

ACKNOWLEDGMENT OF RECEIPT OF PARENT HANDBOOK

Today's Date:

- We _____ the parents of _____have received a copy of the INSERT SCHOOL'S NAME Parent Handbook.
- I agree and understand the policies and procedures listed in this handbook and will comply with the school's rules and regulations.
- I understand that these policies and procedures listed in this handbook are subject to change to reflect the needs of the program.
- I understand I will be made aware of these changes in a timely fashion, and I will always adhere to the most up to handbook.

_____ _____

Parent Signature/Guardian Signature **Date**

_____ _____

Parent Signature/Guardian Signature **Date**