



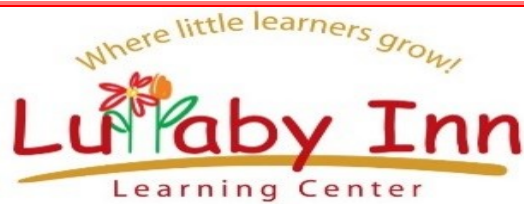
Wentzville • Lake St. Louis

# Infant/Toddler Enrollment Paperwork

## Mission Statement

Lullaby Inn Learning Center recognizes each child as an individual that needs specialized care. We understand that the early childhood years are the most crucial years of a child's development. It sets the pathway for a lifetime of learning. We provide programs which are developmentally appropriate within our safe and nurturing environment. We recognize that children learn at different rates and we are dedicated to meeting the social, emotional, physical and cognitive development of all of our children. Therefore, we have developed a curriculum that will meet the needs of every child that is enrolled at Lullaby Inn Learning Center. The goals of our program are:

- To provide children with a safe learning environment that allows them to develop and grow at an individual rate.
- To provide children with the opportunity to explore and discover themselves and their ability to succeed.
- To promote self respect for themselves as well as others.
- To give children the social skills to help them grow as individuals as well as a group.



## Parent Policies and Procedures

- **Locations-** Lullaby Inn Learning Center (LBI) has locations in Lake Saint Louis and Wentzville, Missouri. The hours of operation are from 6:00am-6:00pm, Monday through Friday.
- **Curriculum-** Curriculum activities are completed daily in each classroom. Both centers utilize Mother Goose Time curriculum which is delivered to each location monthly. The curriculum weaves together art projects, music, storytelling, math, science, and sensory play all around one monthly theme. Parents will receive a monthly newsletter that notifies them about what is being taught in the classroom.
- **Daily Reports-** Parents will be provided with a written daily report for each child. The daily report will keep the parents informed about their child's day including meals, nap times, daily activities, and reminders for parents.
- **Safety and Security-** The doors to our facility remain locked from the outside to ensure that unauthorized individuals do not enter the building. Photo identification is required before a child is released to anyone on the authorized pick up list. High definition cameras are installed in each classroom and are closely monitored in the office.
- **Meals-** Morning snack, lunch and an afternoon snack are included in the weekly tuition rate. Meal times are as follows: Morning snack- 8:30am, Lunch- 11:30am, Afternoon Snack-2:30pm. School-age children returning from school will receive a snack at 3:30pm. Meals will not be served after these designated times. Parents are expected to provide breakfast for any child arriving after 8:30am. Lunch will need to be provided by the parent if the child will be arriving after 11:30am. Parents are responsible for providing formula and/or breast milk for infants enrolled at LBI.
- **Registration Fee-** There is a non-refundable registration fee in the amount of \$100 per child or \$125 for a family. This must be paid prior to enrollment and is required to be placed on the waiting list.
- **Activity Fee-** A \$100 fee will be charged to the account on the 2<sup>nd</sup> week of January on an annual basis. The activity fee covers the cost of curriculum and extracurricular activities throughout the year. It is required to be paid in full by January 31st.
- **Tuition-** Tuition payments are due the Friday before the week of care is provided. Payments can be made weekly, bi-weekly, or monthly if they are paid in advance. LBI accepts payment in the form of cash, money order or credit card. Tuition can automatically be withdrawn from a checking or savings account at no additional cost. There is a 2% processing fee applied to all credit card payments. All families are required to have a Tuition Express agreement on file.
- **Late Tuition Fee-** After one week of non-payment, outstanding account balances will begin accruing late fees at a rate of \$10 per day until the balance is paid in full. Childcare services will be discontinued after 2 weeks of non-payment.
- **School Age Rate-** LBI does allow school age children to attend all day throughout the school year if the public school is closed. Children enrolled in our before and/or after school program will be charged an additional fee of \$5.00 per day for late start/half day care and a \$10 charge for full day care.
- **Rate Increases-** Tuition is subject to yearly increases. Parents will be notified 30 days in advance of any changes in their tuition.
- **Schedule-** Part time care is available for children 2 years of age and older. Part time schedules consist of a minimum of 2 days, maximum of 3. A part time schedule must be consistent each week. Any schedule change request must be in written form and submitted and approved 2 weeks prior to the change.
- **Returned Checks-** If a check is returned due to insufficient funds there will be a fee of \$35 added to the tuition. If a check is returned due to insufficient funds than the parent will be required to begin payments with cash or money order.
- **Late Pick-Up Fee-** LBI closes at approximately 6:00pm, Monday through Friday. The parents will be responsible for paying a fee of \$1.00 per minute after 6:00pm.

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Parent Signature

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Date

- Medical Requirements- LBI is required to have updated shot records on file for your child. We request that you provide us with ongoing updates to ensure that we have the most up to date records.
- Termination of Services- LBI requires a two (2) week written notice if the parent wishes to terminate childcare services. LBI reserves the right to terminate services at any time. Parents will be provided with written notice and a list of referrals if they are given notice.
- Vacation/Illness Tuition- If your child is absent for the entire week (Monday-Friday) the parent will be responsible for 50% of their tuition rate. If the child attends the center even one day than it is the 100% tuition rate for that week.
- Absences- Parents are asked to call the center before 10:00am to report that their child will be absent for the day. LBI reserves the right to deny a family of the 50% off for a full week of absenteeism if the parent does not call to report the absence.
- Holidays- LBI recognizes certain holidays by closing the center. Parents are still responsible for the full tuition rate during the holiday weeks. Days the center will be closed include; Memorial Day, Independence Day, Labor Day, Thanksgiving Day, the day after Thanksgiving, Christmas Eve, Christmas Day, and New Year's Day. We will close at 3:00pm on New Year's Eve. If the holiday falls on a weekend, we will observe either the Friday before or the Monday after as the holiday and the center will be closed. Holiday closings are subject to change. Parents will be notified 30 days in advance of any holiday closings.
- Illness Policy- We understand that it is difficult for parents to take time off when your child is ill. It is for the protection of your child and the other children at the center that we require a child to be sent home if the following symptoms are present; Fever over 100 degrees, 2 or more bouts of diarrhea or vomiting, severe coughing, difficulty breathing, unusual spots or rashes, itching of the scalp.
- Medication- LBI will only administer medication to a child if a "Medication Authorization Form" is completed by the parent. Signature is required as well as the recommended time/dosage. All medications must be brought in the original labeled container with the child's name on it.
- Sign in/out Policy- Parents are required to sign their child in and out daily. Please accompany your child to the classroom and ensure that they are dropped off to an authorized staff member
- Emergency- In the event of a medical emergency LBI is authorized to administer medical care and it is understood that my child will be taken to the nearest hospital to receive medical attention if deemed necessary.
- Nap Time- LBI will have a designated quiet/nap time daily from 12:30pm-2:30pm. Cribs and cots will be individually labeled and provided by the center. LBI will also provide sheets for the cots. It is required that each child be provided with a personal blanket from home for nap time. A pillow is optional; however, it may not be larger than a travel size pillow.
- Online Reviews- Parents agree to not post any public online reviews (including but not limited to Yelp, Facebook, Google Business, etc.) of Lullaby Inn and its affiliates publicly without request or written consent. If an unapproved posting is made, it shall be removed immediately upon request from Lullaby Inn.
- Outside Play- Children will go outside daily if weather is permitting. The Department of Health and Senior Services has determined that any temperature between 20 degrees-90 degrees is a safe temperature and children should be permitted to play outside for a minimum of 5 minutes per day.
- Discipline Policy- LBI believes that all children learn best in a stress-free environment. We strongly believe that redirection is the best method for handling unwanted behavior. Parent/teacher communication is imperative, and we ask the parents to update the teacher if any change in the child's routine are present. LBI will schedule a meeting with the parent if the behavioral concerns persist.
- Licensing Rules and Regulations- LBI retains a copy of the licensing rules and regulations set forth by the Department of Health and Senior Services. A copy is available for your review upon request.

I \_\_\_\_\_ **acknowledge and understand that these policies are not intended to cover every situation that may arise while my child is attending Lullaby Inn. It is simply a general guide to the goals, policies, and practices of the center. By my signature below, I acknowledge and agree to comply with the information provided to me in this handout.**

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
SECTION FOR CHILD CARE REGULATION / BUREAU OF COMMUNITY FOOD & NUTRITION ASSISTANCE  
**CHILD CARE ENROLLMENT FORM**

FACILITY/PROVIDER NAME	ADMISSION DATE	DISCHARGE DATE
CHILD'S NAME	GENDER	BIRTHDATE
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

**IDENTIFYING INFORMATION**

MOTHER'S/GUARDIAN'S NAME	HOME TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE <input type="checkbox"/>	CELL PHONE NUMBER
E-MAIL ADDRESS	
EMPLOYER OR SCHOOL ATTEND	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER
FATHER'S/GUARDIAN'S NAME	HOME TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE <input type="checkbox"/>	CELL PHONE NUMBER
E-MAIL ADDRESS	
EMPLOYER OR SCHOOL ATTEND	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER

**EMERGENCY CONTACT AND PERSONS AUTHORIZED TO TAKE CHILD FROM FACILITY**  
(OTHER THAN PARENT) AT LEAST ONE EMERGENCY CONTACT IS REQUIRED.

NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBERS (CELL, WORK, HOME)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		
NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBERS (CELL, WORK, HOME)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

**COMMENTS ON CHILD'S DEVELOPMENT**  
(PERSONAL DEVELOPMENT, BEHAVIOR, PATTERNS, HABITS, & INDIVIDUAL NEEDS)

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**RELATED CHILD**

☐ YES ☐ NO HOW IS CHILD RELATED TO CHILD CARE PROVIDER?

**CHILD'S PROJECTED ATTENDANCE SCHEDULE AND ANY VARIATIONS EXPECTED**

<b>CACFP REQUIREMENT</b>	CHECK HERE WHAT DAYS THE CHILD WILL ATTEND. WILL CHILD ATTEND: <input type="checkbox"/> FULL TIME OR <input type="checkbox"/> PART TIME	WHAT TIME DOES YOUR CHILD USUALLY ARRIVE EACH DAY? CIRCLE AM OR PM	WHAT TIME DOES YOUR CHILD USUALLY LEAVE EACH DAY? CIRCLE AM OR PM	WRITE ANY COMMENTS, CHANGES OR VARIATIONS IN USUAL ATTENDANCE IN THIS SECTION INCLUDING SHIFT CHANGES.
	MONDAY <input type="checkbox"/>	AM PM	AM PM	
	TUESDAY <input type="checkbox"/>	AM PM	AM PM	
	WEDNESDAY <input type="checkbox"/>	AM PM	AM PM	
	THURSDAY <input type="checkbox"/>	AM PM	AM PM	
	FRIDAY <input type="checkbox"/>	AM PM	AM PM	
	SATURDAY <input type="checkbox"/>	AM PM	AM PM	
	SUNDAY <input type="checkbox"/>	AM PM	AM PM	

<b>CACFP REQUIREMENT</b>	<b>CHECK THE MEALS YOUR CHILD IS USUALLY GIVEN AT THIS FACILITY</b>			
	<input type="checkbox"/> BREAKFAST <input type="checkbox"/> MORNING SNACK <input type="checkbox"/> LUNCH <input type="checkbox"/> AFTERNOON SNACK <input type="checkbox"/> SUPPER <input type="checkbox"/> EVENING SNACK <input type="checkbox"/> NONE			
	<b>CHECK THE HOLIDAYS YOUR CHILD IS IN CARE AT THIS FACILITY</b>			
	<input type="checkbox"/> NEW YEAR'S DAY (JANUARY)	<input type="checkbox"/> MARTIN LUTHER KING JR.'S BIRTHDAY (JANUARY)	<input type="checkbox"/> PRESIDENT'S DAY (FEBRUARY)	<input type="checkbox"/> EASTER (MARCH/APRIL)
	<input type="checkbox"/> MEMORIAL DAY (MAY)	<input type="checkbox"/> INDEPENDENCE DAY (JULY)	<input type="checkbox"/> LABOR DAY (SEPTEMBER)	<input type="checkbox"/> COLUMBUS DAY (OCTOBER)
<input type="checkbox"/> VETERANS DAY (NOVEMBER)	<input type="checkbox"/> ELECTION DAY (NOVEMBER)	<input type="checkbox"/> THANKSGIVING (NOVEMBER)	<input type="checkbox"/> CHRISTMAS DAY (DECEMBER)	
<b>AUTHORIZATION FOR EMERGENCY MEDICAL CARE</b>				
I UNDERSTAND THAT I WILL BE NOTIFIED AT ONCE IN CASE OF AN EMERGENCY WITH MY CHILD, AND I WILL MAKE ARRANGEMENTS FOR MEDICAL CARE OF MY CHILD WITH THE PHYSICIAN OR HOSPITAL OF MY CHOICE.  IF I CANNOT BE REACHED TO MAKE NECESSARY ARRANGEMENTS, OR IN A CRITICAL EMERGENCY REQUIRING MEDICAL CARE, I AUTHORIZE  <div style="text-align: center;">DAY CARE PROVIDER OR HOME PROVIDER</div> TO CONTACT THE FOLLOWING:				
<b>PHYSICIAN OR CLINIC</b>				
NAME				TELEPHONE NUMBER
<b>PREFERRED HOSPITAL</b>				
NAME				TELEPHONE NUMBER
<b>ACKNOWLEDGEMENTS</b>				
A	I HAVE RECEIVED A COPY OF THIS FACILITY'S POLICIES PERTAINING TO THE ADMISSION, CARE AND DISCHARGE OF CHILDREN.			PARENT/GUARDIAN INITIALS
B	I HAVE BEEN INFORMED THAT A COPY OF THE LICENSING RULES FOR CHILD CARE HOMES OR THE LICENSING RULES FOR GROUP CHILD CARE HOMES AND CENTERS IS AVAILABLE AT THIS FACILITY FOR REVIEW.			PARENT/GUARDIAN INITIALS
C	THE PROVIDER AND I HAVE AGREED ON A PLAN FOR CONTINUING COMMUNICATION REGARDING MY CHILD'S DEVELOPMENT, BEHAVIOR, AND INDIVIDUAL NEEDS.			PARENT/GUARDIAN INITIALS
D	WHEN MY CHILD IS ILL, I UNDERSTAND AND AGREE THAT S/HE MAY NOT BE ACCEPTED FOR CARE OR REMAIN IN CARE.			PARENT/GUARDIAN INITIALS
E	I UNDERSTAND THAT, BEFORE THE FIRST DAY OF ATTENDANCE BY MY CHILD, I WILL PROVIDE PROOF OF COMPLETED AGE-APPROPRIATE IMMUNIZATIONS OR EXEMPTION FROM IMMUNIZATIONS.			PARENT/GUARDIAN INITIALS
F	<input type="checkbox"/> DO <input type="checkbox"/> DO NOT GIVE PERMISSION FOR FIELD TRIPS/EXCURSIONS. I UNDERSTAND I WILL BE NOTIFIED IN ADVANCE WHEN THEY ARE PLANNED.			PARENT/GUARDIAN INITIALS
G	<input type="checkbox"/> DO <input type="checkbox"/> DO NOT GIVE PERMISSION FOR THE FACILITY TO TRANSPORT MY CHILD.			PARENT/GUARDIAN INITIALS
H	I HAVE BEEN INFORMED AND HAVE RECEIVED A COPY OF THE FACILITY'S SAFE SLEEP POLICY WHEN ENROLLING A CHILD LESS THAN ONE (1) YEAR OF AGE.			PARENT/GUARDIAN INITIALS
I	I HAVE BEEN NOTIFIED THAT I MAY REQUEST NOTICE AT INITIAL ENROLLMENT OR ANY TIME THERE AFTER WHETHER THERE ARE CHILDREN CURRENTLY ENROLLED IN OR ATTENDING THE FACILITY FOR WHOM AN IMMUNIZATION EXEMPTION HAS BEEN FILED.			PARENT/GUARDIAN INITIALS
PARENT'S/GUARDIAN'S SIGNATURE				DATE
<b>CACFP REQUIREMENT</b>	FIRST ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE		DATE
	SECOND ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE		DATE
	THIRD ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE		DATE



IDENTIFYING INFORMATION	
1. Name of the person or entity	
2. Address	
3. City	
4. State	
5. Zip	
6. Date of birth	
7. Social Security Number	
8. Other identifying information	

BIRTHDATE

Based on my assessment of this child's medical history, current state of health and my physical examination of the child on \_\_\_\_ / \_\_\_\_ / \_\_\_\_, this child can participate in a child care program. This child has no special care needs unless specified below.

*(Date of medical examination must be within the last 12 months.)*

Complete this section only if child requires special care at a child care facility, e.g. special diets, allergies, ear infections, convulsions, diabetes, asthma, behavior problems, hearing or visual impairment, etc. (Attach additional pages as needed.)

[illegible]

DATE
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PHYSICIAN'S OR NURSE'S NAME (PLEASE PRINT)

IF NURSE IS SUPERVISED BY A PHYSICIAN, INDICATE PHYSICIAN'S NAME  
(PLEASE PRINT.)

TELEPHONE NUMBER



## Emergency Form

Child's Name \_\_\_\_\_ Age \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Phone Number \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Mother's Name \_\_\_\_\_ Work Hours \_\_\_\_\_  
Place of Employment \_\_\_\_\_  
Work Phone \_\_\_\_\_ Extension \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Father's Name \_\_\_\_\_ Work Hours \_\_\_\_\_  
Place of Employment \_\_\_\_\_  
Work Phone \_\_\_\_\_ Extension \_\_\_\_\_ Cell Phone \_\_\_\_\_

### Alternate Contacts

Name _____	Relationship _____
1 <sup>st</sup> Phone Number _____	2 <sup>nd</sup> Phone Number _____
Name _____	Relationship _____
1 <sup>st</sup> Phone Number _____	2 <sup>nd</sup> Phone Number _____
Name _____	Relationship _____
1 <sup>st</sup> Phone Number _____	2 <sup>nd</sup> Phone Number _____

Doctor \_\_\_\_\_ Phone Number \_\_\_\_\_  
Important Medical Information/Allergies \_\_\_\_\_

Please list anyone other than your emergency contacts that is authorized to pick up your child from Lullaby Inn:

_____	_____
_____	_____
_____	_____



Purpose: The purpose of the Safe Sleep Policy is to maintain a safe sleep environment that reduces the risk of sudden infant death syndrome (SIDS) and sudden unexpected infant deaths (SUIDS) in children less than one year of age.

Missouri law requires all licensed child care facilities that provide care for children less than one year of age to implement and maintain a written safe sleep policy in accordance with the most recent safe sleep recommendations of the American Academy of Pediatrics (AAP). Missouri child care licensing rules require licensed child care facilities to provide parent(s) and/or guardians who have infants in care be provided a copy of the facility's safe sleep policy. Child care providers can maintain safer sleep environments for infants that help lower the chances of SIDS. Our goal is take proactive steps to reduce the risk of SIDS in child care and to work with parents to keep infants safer while they sleep. To do so, this facility will practice the following safe sleep policy:

### **Safe Sleep Practices**

1. Infants, less than one (1) year of age will always be placed on their backs to sleep.
2. When infants can easily turn from their stomachs to their backs and from their backs to their stomachs, they shall be initially placed on their backs, but shall be allowed to adopt whatever positions they prefer for sleep. We will follow this recommendation by the American Academy of Pediatrics.
3. Sleeping infants shall have a supervised nap period. The caregiver shall check on the infant frequently during napping or sleeping and shall remain in close proximity to the infant in order to hear and see them if they have difficulty during napping or when they awaken.
4. Equipment such as a sound machine, that may interfere with the caregiver's ability to see or hear a child who may be distressed, is prohibited.
5. Steps will be taken to keep infants from overheating by regulating the room temperature, avoiding excess bedding, and not over-dressing or over-wrapping the infant. Infants should be dressed appropriately for the environment, with no more than one (1) layer more than an adult would wear to be comfortable in that environment.
6. The lighting in the room must allow the caregiver/teacher to see each infants face, to view the color of the infant's skin, and to check on the infant's breathing and placement of the pacifier (if used).
7. All caregivers will receive in-person or online training on infant safe sleep based on AAP safe sleep recommendations. This training must be completed within 30 days of employment or volunteering and will be completed every three years.



## Safe Sleep Environment

1. Room temperature will be kept at no less than 68 degrees F and no more than 85 degrees F when measured two feet from the floor. Infants are supervised to ensure they are not overheated or chilled.
2. Infants' heads and face will not be covered during sleep. Infants' cribs will not have blankets or bedding hanging on the sides of the crib. **We may use sleep clothing (i.e. sleep sack, sleepers) that is designed to keep an infant warm without the possible hazard of covering the head or face during sleep/nap time.**
3. No blankets, loose bedding, comforters, pillows, bumper pads, or any object that can increase the risk of entrapment, suffocation or strangulation will be used in cribs, playpens or other sleeping equipment.
4. Toys and stuffed animals will be removed from the crib when the infant is sleeping. **When indicated on the *Infant and Toddler Feeding and Care Plan* or with written parent consent, pacifiers will be allowed in infants' cribs while they sleep. The pacifier cannot have cords or attaching mechanisms.**
5. Only an individually-assigned safety-approved crib, portable crib, or playpen with a firm mattress and tight-fitting sheet will be used for infant napping or sleeping.
6. Only one infant may occupy a crib or playpen at one time.
7. Sitting devices such as car safety seats, strollers, swings, infant carriers, infant slings, and other sitting devices will not be used for sleep/nap time. Infants who fall asleep anywhere other than a crib, portable crib, or playpen must be placed in the crib or playpen for the remainder of their sleep or nap time.
8. No person shall smoke or otherwise use tobacco products in any area of the child care facility during the period of time when children are cared for under the license are present.
9. Home monitors or commercial devices marketed to reduce the risk of Sudden Infant Death Syndrome (SIDS) shall not be used in place of supervision while children are napping and sleeping.
10. All parents/guardians of infants shall be informed of and given the facility's written Safe Sleep Policy at enrollment.
11. To promote healthy development, infants who are awake will be given supervised "tummy time" for exercise and for play.

If you have any questions regarding this information please do not hesitate to speak with a member of the management team. Please sign below to acknowledge that you have read through this form and that you understand the information that is provided.

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Parent Signature

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Date



Missouri Department of Health and Senior Services  
Section for Child Care Regulation and Child and Adult Care Food Program  
**INFANT AND TODDLER FEEDING AND CARE PLAN**

**THIS SECTION TO BE COMPLETED BY CHILD CARE FACILITY:**

The formula provided by this child care facility is: \_\_\_\_\_.

**(Check a box)** ☐ Yes ☐ No This child care facility **is participating** in the Child and Adult Care Food Program (CACFP). In order to claim meals for reimbursement, the center must provide infant cereal and other foods when the child is developmentally ready for them.

**Instructions to Parents** – Please complete for child who is less than 24 months of age. Update information as needed. Use a new form or initial/date changes on this form.

CHILD'S NAME

DATE OF BIRTH

DATE ENROLLED

**Feeding Information**

Type of Food	Feeding Time	Kinds of Food	Amount of Food
Breast Milk			
Formula			
Infant Food			
Table Food			

Who is preparing (mixing) the formula? Check all that apply: ☐ Parent ☐ Caregiver

Does your child have any problems with feedings, such as choking or spitting up?

☐ Yes Explain: \_\_\_\_\_

☐ No

Does your child use a pacifier? ☐ Yes ☐ No

**Note:** Pacifiers, if used, cannot be hung around an infant's neck. Pacifier mechanisms or pacifiers that attach to infant clothing cannot be used with sleeping infants.

**Infant Feeding Preference (under 12 months)**

Mark your preference (check all that apply).

☐ I will provide breast milk for my infant.

☐ I will nurse my infant at the center at these times: \_\_\_\_\_

The facility's formula may be used to supplement feedings if necessary: ☐ Yes ☐ No

If breast milk is unavailable for a feeding, the facility should: \_\_\_\_\_

☐ I request that the formula provided by the child care facility be served to my infant.

☐ I will provide infant formula for my infant. Name of formula: \_\_\_\_\_

☐ I request that the child care facility provide solid foods for my infant as s/he is ready for them, and after I have discussed it with child care facility staff. **OR**

☐ I will provide solid foods for my infant.

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Toddler Feeding Preference (12 through 23 months)			
Check all that apply: <input type="checkbox"/> Spoon <input type="checkbox"/> Cup <input type="checkbox"/> Feeds Self <input type="checkbox"/> Feeding Table or Chair			
Type of Food	Feeding Time	Kinds of Food	Amount of Food
Breast Milk			
Milk			
Table Food			
<b>Arrangements for Sleep – Licensing rules require that infants be placed on their back to sleep.</b>			
Time(s) Child Usually Naps		Length of Nap	
<b>Additional Instructions Related to Sleeping:</b> <b>Note:</b> When, in the opinion of the infant's licensed health care provider, an infant requires alternative sleep positions or special sleeping arrangements that differ from those required by rule, the provider must have on file at the facility written instructions, signed by the infant's licensed health care provider, detailing the alternative sleep positions or special sleeping arrangements for such infant. The caregiver(s) must put the infant to sleep in accordance with such written instructions.			
<input type="checkbox"/> My child is 12 months or older, and I give my permission for my child to sleep on a cot.			
Signature of Parent/Legal Guardian		Date	
<b>Diapering Instructions</b>			
List any lotions and/or ointments, etc. that you have provided and give permission for caregivers to use on your child. _____			
For <input type="checkbox"/> Wet <input type="checkbox"/> Bowel Movement <input type="checkbox"/> Rash <input type="checkbox"/> Other			
<input type="checkbox"/> I do not want caregivers to use any lotions, powders, ointments or similar items on my child.			
I will furnish the following baby supplies for my child; clearly labeled with my child's name:			
Special Instructions for Care (e.g., restrictions, allergies, etc.):			
Signature of Parent/Legal Guardian		Date	



## Toilet Training Service Agreement

At Lullaby Inn, it is our goal to help your child reach their developmental milestones while enrolled in our program. Toilet training is a critical part of development and it is our mission to assist your family with reaching this goal. Each child presents with their own unique set of circumstances that influence the duration of time it takes to achieve completion. Continued reinforcement at home plays an important role in ensuring that your child will have the highest rate of success. It is important for parents to recognize that we do not provide any guarantees. Collaboration between the teacher and parent is necessary during the toilet training process.

We encourage you to consult with your child's pediatrician to evaluate if he/she is developmentally ready before beginning the toilet training process.

It is the responsibility of the parent/guardian to provide all necessary items prior to beginning the toilet training process. These items include but are not limited to: **(3) extra changes of clothes, pull-ups or training undergarments, and wipes.** These items are of great necessity to the toilet training process and must be kept at the center always. Soiled clothing will be sent home in a bag at pick up and it will be the responsibility of the parent to launder those items. Toilet training will include positive reinforcement and will follow a routine established between Lullaby Inn and the parents/guardians. The teacher will provide ongoing feedback about your child's progress and a daily report of scheduled bathroom breaks and their outcome.

I, the parent/legal guardian of the child listed below, hereby give my full consent and approval for my child to participate in the toilet training process. I certify that my child is fully capable of participating in toilet training and there are no restrictions placed upon him/her that would hinder this process. In addition to giving my full consent for my child's participation, I do hereby waive, release, and hold harmless the organization of Lullaby Inn for any injury that may be suffered by my child in the normal course of participation in the toilet training process. I agree to keep the teacher updated on progress at home and provide all necessary items outlined in this service agreement. I understand that failure to provide these items may void this agreement and that toilet training services will be interrupted until the supplies are provided.

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

Date to begin toilet training: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



### **Cot Consent**

I, \_\_\_\_\_, give permission for my child, \_\_\_\_\_, to sleep on a cot once they are over the age of 12 months and have transferred to the toddler unit. I consent to my child sleeping on a cot and I am aware that the cots are raised an average of 6 inches off of the ground.

### **Sunblock Consent**

I, \_\_\_\_\_, give permission for my child, \_\_\_\_\_, to be administered sun block when going outdoors. I understand that sunblock will be provided by the parent and will be kept at the center at all times.

### **Bug Spray Consent**

I, \_\_\_\_\_, give permission for my child, \_\_\_\_\_, to be administered bug spray when going outdoors. I understand that bug spray will be provided by the parent and will be kept at the center at all times.

### **Photo Consent**

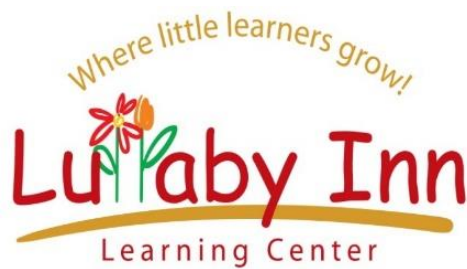
I, \_\_\_\_\_, give permission for Lullaby Inn to use my child, \_\_\_\_\_, photo for the purpose of printing/publishing them in newspapers, magazines, flyers, posters, articles, advertisements, banners, signs, Facebook, etc.

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Parent Signature

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Date



## Photo Consent Form

Printed name of person completing this form: \_\_\_\_\_

I have been informed that Lullaby Inn Learning Center does utilize pictures of the children for marketing tools on multiple forums. By initialing the lines below, I grant Lullaby Inn and its affiliates to use my child's images for the purposes outlined in the description. I agree that allowing my child's photograph to be used is on a voluntary basis and that I will not receive any monetary compensation for the release of these photos. Furthermore, I hereby release Lullaby Inn and its legal representatives from all claims and any liability relating to these images. I understand that I can deny consent for my child's photographs to be used by completing the section at the bottom labeled "Refusal of Content."

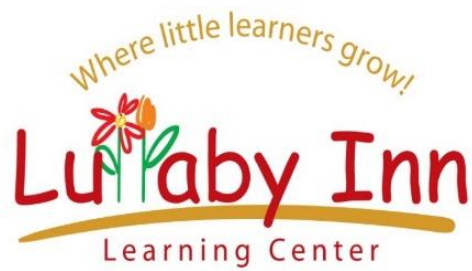
\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

Please list the first and last name of the child(ren) below each line if you are consenting to the photo release of their images. Children under one household will not be photographed unless they are outlined individually in each initialed section.

- \_\_\_\_\_ **Photographs can be used for classroom projects and may be displayed throughout the center**  
Permission granted for: \_\_\_\_\_
- \_\_\_\_\_ **Photographs can be posted on social media forums, including but not limited to, Facebook, Instagram, Twitter, etc.**  
Permission granted for: \_\_\_\_\_
- \_\_\_\_\_ **Photographs can be used for promotional materials, such as brochures and fliers**  
Permission granted for: \_\_\_\_\_
- \_\_\_\_\_ **Photographs can be used for fundraising purposes and to raise awareness about upcoming events at the center**  
Permission granted for: \_\_\_\_\_
- \_\_\_\_\_ **Photographs can be used for newspaper or magazine publication**  
Permission granted for: \_\_\_\_\_
- \_\_\_\_\_ **Photographs can be posted on the company web site for promotional purposes**  
Permission granted for: \_\_\_\_\_

\*Please see the other side of this form and complete additional information



## Photo Consent Form

Child's Name: \_\_\_\_\_

I \_\_\_\_\_ am the parent/legal guardian of the children listed on this form. I hereby grant permission to Lullaby Inn to take and use digital images of my child for the specific use identified by my initials. I recognize that this agreement is in full affect and that it is my responsibility to update this form if I would like to make changes to the release.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

## Refusal of Consent

Child's Name: \_\_\_\_\_

I \_\_\_\_\_ have read the information outlined on this form and do **not** consent to the release of my child's digital images for any purpose. I understand that this includes the use of photographs for any classroom projects that my child may create during curriculum.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date



## Playground Release Form

Parent(s) Name(s) \_\_\_\_\_

Child's Name(s) \_\_\_\_\_

DOB \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_

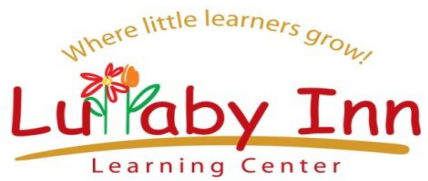
I hereby consent my child(ren) \_\_\_\_\_ to use all of the playground equipment at Lullaby Inn Learning Center. Equipment of the playground includes climbing structures, slides, bikes, scooters, hula hoops, balls, etc. I recognize that injuries may occur. I fully understand that the members of Lullaby Inn Learning Center are not physicians or medical practitioners of any kind. With the above in mind, I hereby allow the staff members of Lullaby Inn Learning Center to render first aid to my child or children in the event of any injury or illness. Furthermore, if deemed necessary by Lullaby Inn Learning Center, I give them my permission to call 911 to seek medical help, including transportation to any health care facility or hospital.

I understand that it is the express intent of Lullaby Inn Learning Center to provide for the safety and protection of my child(ren), and in consideration for allowing my child(ren) to play on the playground equipment. I hereby release Lullaby Inn Learning Center, its employees, and owners from all liability for any and all damages and injuries suffered by my child (ren) while playing with/on the playground equipment. I also affirm that I now have and will continue to provide proper hospitalization, health, and accident insurance coverage, which I consider adequate for my child (ren) protection and my own protection. I also understand that my child (ren) will be with supervision at all times they are playing with/on the playground equipment. This acknowledgment of risk and waiver of liability, having been read thoroughly and understood completely, is signed voluntarily as to its content and intent.

\_\_\_\_\_  
Parent or Legal Guardian Signature

\_\_\_\_\_  
Date





## All About Me

Child's Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Parents Names: \_\_\_\_\_

I have \_\_\_\_ brothers and \_\_\_\_ sisters, their names and ages are: \_\_\_\_\_

\_\_\_\_\_

Has your child been in childcare before? Yes\_\_\_\_ No\_\_\_\_

Does your child have a regular bedtime schedule? Yes\_\_\_\_ No\_\_\_\_

What time does your child usually wake up in the morning? \_\_\_\_\_

Are there any special dolls, blankets, etc. that your child needs to go to sleep?

\_\_\_\_\_

Has or does your child have any known health problems? Yes\_\_\_\_ No\_\_\_\_

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

Does your child take daily medications? Yes\_\_\_\_ No\_\_\_\_

If yes, what medication and when is it given? \_\_\_\_\_

Does your child have any known allergies? Yes\_\_\_\_ No\_\_\_\_

If yes, please list allergies: \_\_\_\_\_

Is your child prone to: upset stomach, colds, seasonal allergies, ear aches,

headaches, sore throats, nose bleeds, other: \_\_\_\_\_

Are there any indications of hearing or vision problems? \_\_\_\_\_

Does your child have any physical or mental disabilities? Yes\_\_\_\_ No\_\_\_\_

If yes, please explain: \_\_\_\_\_

What are your child's eating habits? (Trying new things, picky eater, eats great)

\_\_\_\_\_

Does your child have a special diet? \_\_\_\_\_

How would you describe your child's personality? \_\_\_\_\_

\_\_\_\_\_

How does your child get along with other children? \_\_\_\_\_

\_\_\_\_\_

Are there any recent family events or changes? (moving, death, divorce, marriage, new sibling, etc.) \_\_\_\_\_

\_\_\_\_\_

Your normal drop off time will be \_\_\_\_\_ and pick up will be \_\_\_\_\_

Is there anything you would like us to know about your child? \_\_\_\_\_

\_\_\_\_\_

What are your expectations of this program? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

These questions were answered by: \_\_\_\_\_



## Tuition Express Agreement

Lullaby Inn Learning Center uses Procare Software and Tuition Express for all tuition information, charges, and payments. This is to make tuition payments and account information more convenient for parents.

Lullaby Inn Learning Center is a self-supporting program. Registration, tuition, and yearly fees are used to cover operating expenses for our school. Tuition is due the Friday before the week of care by 6pm to not be considered late. A late fee of \$10.00 per day will be charged each day after payment is due. If a payment is declined or returned for any reason, a \$35.00 fee will be charged to your account.

You have the option to pay weekly tuition by:

- ACH Payment (auto withdrawal from a checking account)
- Credit Card Payment (in person or online—2% processing fee will be applied)
- Cash, Check, or Money Order

Our company requires every family enrolled at Lullaby Inn to have a credit card/checking account on file (See Credit and ACH authorization paperwork). Lullaby Inn reserves the right to charge the account on file if the outstanding balance is two weeks past due. If the parent decides to terminate childcare services, Lullaby Inn does require a written two-week notice informing the center of the change. Lullaby Inn will charge any outstanding balance to your credit card or checking account on file if payments are not made in full by the last date of attendance. For any tuition questions or comments, please email the Regional Manager, Brianna Adkins, at [badkins@lullabyinn.com](mailto:badkins@lullabyinn.com).



## Tuition Express Agreement

I want to enroll in Tuition Express and have my weekly tuition automatically withdrawn from my Checking/Savings account:

Yes ☐ No ☐

I want to enroll in Tuition Express and have my weekly tuition automatically withdrawn from my credit/debit card and understand there will be a 2% processing fee applied to each payment:

Yes ☐ No ☐

I will have an updated credit/debit card or checking account on file at all times while my child is enrolled at Lullaby Inn.

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Parent or Guardian Signature

---

Date

I have read the Tuition Express Agreement and understand that my credit card or checking account on file will be charged if my outstanding balance is two weeks delinquent and/or services are terminated with a remaining balance owed.

---

Parent or Guardian Signature

---

Date



## Automated Payment Processing Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express®—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)	<input type="checkbox"/> Checking <input type="checkbox"/> Savings
Authorized Signature	Date	

#### For Official Use Only

Date Received

Employee Signature

John Sample Mary Sample 123 Nice Street Anytown, USA	BANK OF THE WEST 555-555-5555	00226
Pay to the order of:	Attach Voided Check Here	\$
	Deposit slips not accepted	Dollars
123456789	1800330	0226
Routing Number	Account Number	Check Number

A service of

