3214 50th St Ct., Suite 102 | Gig Harbor, WA 98335
LittleStepsChristianChildcare@gmail.com | 253.851.2484

Registration 2024

Child's Name: _____
Last First Middle Nickname

Date of Birth: _____

Parent's Name: _____ Cell #: _____

Registration Fees:

New Enrollment Registration Fee: $200 per child (non-refundable)
Annual Re-registration Fee: $100 per child (non-refundable)

Initial registration fee is due with your child's enrollment forms, immunization records, and student medical information sheet. A parent / Preschool Director orientation is required prior to your child's first day of service.

2024 Tuition Rates *4-5 days per week*	1st child FULL TIME monthly rate	2nd child 10% discount monthly rate
6 weeks–1 year old	$1,600	$1,440
1 year old (12-23 months)	$1,300	$1,170
2 years old (24-35 months)	$1,200	$1,080
Preschool (3-5 years)	$1,085	$976.50

Rates are based on 52 weeks per year.
Rates will not be adjusted for holidays, sick days, or vacations falling within a month.
Holidays (closures) include: MLK Day, Presidents Day, Memorial Day, Juneteenth (6/19), Independence Day, Labor Day, Veteran's Day, Thanksgiving & Thanksgiving Friday, Christmas Break (Dec 25-Jan 1st).
An additional center cleaning date maybe added in the summer.

In agreement:

_____
Parent Signature Date

Revised 9/22/23 BOD approved.

Little Steps Christian Learning Center does not discriminate based on race, color, class, religion, disability, national or ethnic origin.

All GOD's Children are Welcome!

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Financial Policy & Parent Agreement

Your account:

- All payments are prepaid one month in advance.
- Payments will be **DUE by the 5TH of each month** for the upcoming month.
- Full tuition is applied to your youngest child, unless they are part time only.
- One discount will be allotted per child, the greater discount will apply.
- Rates will not be adjusted for holidays, sick days, or vacations falling within a month.
- **$25.00 Late Fee** is applied to payments received after the 5th of the month.
- **$25.00 NSF charge** is applied to all returned checks.
- Late Pick up fees will be added to the upcoming month's invoice (see Parent Handbook for details).
- Since tuition accounts are paid in advance, all adjustments or additional charges will be due at the beginning of the following month.
- A 30-day notice is requested for termination of this contract. *Initials* _____
- Accounts which are 15 days PAST DUE will result in a conference with the Director. If a mutually agreeable and reasonable solution cannot be reached, the parents may be informed their child(ren) will not be able to continue attending Little Steps until payment in full has been received. *Initials* _____

BY SIGNING AND SUBMITTING THIS APPLICATION I HEREBY ACKNOWLEDGE THE FOLLOWING:

1. That Little Steps has the right to terminate this contract at any time if my child's behavior is found unacceptable by the Directors.
2. That Little Steps has full responsibility for selecting the appropriate curriculum for my child, per state guidelines.
3. I will release Little Steps from all liability, except in the case of neglect/abuse, while my child is under Little Steps care and responsibility.
4. I will repay Little Steps for all damages caused by my child.
5. I agree to fulfill all financial obligations promptly, in agreement with Little Steps financial policy.
6. I will fully support the school's Biblical teachings, behavioral, and other policies.
7. I understand that all required registration forms must be completed and returned, as well as completing the parent/director orientation for this application to be valid.
8. I realize that any intentional withholding of pertinent information regarding this contract could result in the dismissal of my child; and
9. I fully understand that the Registration fee must be paid in full for this application to be valid.

I have read, understand, and agree with the above information and requirements.
In agreement:

Parent Signature Date

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Student Information Form Pg. 1 of 2

Must Accompany the Student Medical Release Form

Start date: M T W T F

First Last M.I. Nickname

Age: _____Birth Date: _____ Male_____ Female_____

Mother/Guardian Phone

First Last

Mother - Place of Work

Work Address (where you can be reached while child is in our care) Work Phone #

Mother's Email Father's Email

Mother's Address

Street City State Zip Code

Father/Guardian Phone

First Last

Father - Place of Work

Work Address (where you can be reached while child is in our care) Work Phone #

Father's Address

Street City State Zip Cod

OTHER PEOPLE TO NOTIFY IN CASE OF EMERGENCY

Name Contact Numbers Relation

1. _____

2. _____

Out of State contact

3. _____

Health Information

YES__ NO__ALLERGIES If yes, please supply us with a Family Food Allergy History Form and/or Anaphylaxis Emergency Action Plan. Both forms are available on our website. What are your child's Allergies?

_____

YES___NO__ Regular Medication If yes, please list

_____

YES NO Does your child have any physical, mental, emotional, behavioral problems, or any unusual family circumstances that we should be aware of? If yes, please give details

_____

_____

YES NO Has your child been in childcare before? Where? And have they ever been expelled from a center?

_____

_____

Student information/ Medical / Release Form

Part 2 of 2

Doctor_____Phone_____Address_____Exam date_____

Medical insurance
carrier_____ID#_____Group#_____

Dentist_____Phone_____Address_____

CONSENT TO MEDICAL CARE AND TREATMENT OF MINOR CHILDREN

I, herby give permission that my child, _____,

May be given emergency treatment by a qualified childcare provider at: **Little Steps Christian Childcare of Gig Harbor** 3008 36th Street NW Bldg. A, Gig Harbor WA 98335. When I cannot be contacted, I authorize and consent to medical, surgical, and hospital care, treatment, and procedures to be performed for my child by a licensed physician, health care provider, hospital or aid car attendant when deemed necessary to safeguard my child's health. I waive my right of informed consent to such treatment. I also give permission for my child to be transported by ambulance or aid car to an emergency center for treatment. I also certify (or declare) under penalty of perjury under the laws of the State of Washington the foregoing is true and correct.

_____ _____

Parent/Guardian signature Date Parent/Guardian signature Date

RELEASE INFORMATION: Other than you, who has permission to pick up your child: As the child's legal parent/guardian we authorize release of our child to the following people: **MUST BE 18 YEARS OLD OR OLDER**

Name	**Relationship**	**Phone**
_____	_____	_____
_____	_____	_____

Please notify our director or staff if a designated person other than you, will be picking up your child. They must show ID.

Who does not have permission to pick up my child? And why?_____

Name: _____ Relationship: _____

PHOTO PERMISSION YES__NO__ I hereby grant Little Steps permission to use my child's likeness in photograph(s) in all of its publications and in any and all media, whether now known or hereafter existing, controlled by Little Steps Christian Childcare of GH. I will make no claim against LS for the use of photos. I understand LS will not publish or use any personal information about my child. **Trip Permission** YES__NO__ Campus and offsite field trips, Little Steps Christain Childcare center conducts. For offsite field trips I understand that I will either personally drive my child or arrange other transportation to the activity for my child. **Other Permissions** Yes__NO__ I give permission for my child to have sunscreen applied as needed. **Other Permissions** Yes__NO__ I give permission for my child to have sunscreen applied as needed.

Discover | Learn | Grow

Annual Family Culture Questionnaire

1. Who lives in the home? Who is the child's primary caretaker(s)?

_____
_____
_____

2. What are your goals in life and for your children?

_____
_____
_____

3. What are your favorite memories of your family?

_____
_____
_____

4. How does your family have fun?

_____
_____
_____

5. What are your family's rules?

_____
_____
_____

6. How does your family support each other?

_____
_____
_____

7. What are your traditions or favorite cultural activities?

_____
_____
_____

8. What do you believe in (religious or otherwise)?

_____
_____
_____

9. What is the most important thing I should know about your child?

_____
_____
_____
_____

10. My child learns best when the teacher is….

_____
_____
_____

11. My child does not work well with…

_____
_____
_____

12. What is your child's favorite book?

_____

13. What is your child's favorite song?

_____

14. What fears does your child have? (Big or small)

_____
_____
_____

15. What is the best way to motivate your child?

_____
_____
_____

16. What Language or languages are spoken in your home?

_____
_____
_____

17. Do you have any behavioral concerns for your child?

_____
_____
_____

18. Do you have any developmental concerns for your child?

_____
_____
_____

Family Food Allergy Health History Form

Student Name: _____ Date of Birth: _____
Parent/Guardian: _____ Today's Date: _____
Home Phone: _____ Work: _____ Cell: _____
Primary Healthcare Provider: _____ Phone: _____
Allergist: _____ Phone: _____

1. Does your child have a diagnosis of an allergy from a healthcare provider: ❑ No ❑ Yes

2. History and Current Status

a. What is your child allergic to?
- ❑ Peanuts ❑ Insect Stings
- ❑ Eggs ❑ Fish/Shellfish
- ❑ Milk ❑ Chemicals _____
- ❑ Latex ❑ Vapors _____
- ❑ Soy ❑ Tree Nuts (walnuts, pecans, etc.)
- ❑ Other: _____

b. Age of student when allergy first discovered:_____
c. How many times has student had a reaction?
❑ Never ❑ Once ❑ More than once, explain:
_____
d. Explain their past reaction(s): _____
e. Symptoms: _____
f. Are the food allergy reactions: ❑ Same ❑Better ❑ Worse

3. Trigger and Symptoms

a. What are the early signs and symptoms of your student's allergic reaction? *(Be specific; include things the student might say.)* _____
_____

b. How does your child communicate his/her symptoms? _____

c. How quickly do symptoms appear after exposure to food(s)? _____secs. _____mins. _____hrs. _____days

d. Please check the symptoms that your child has experienced in the past:

Skin:	❑ Hives	❑ Itching	❑ Rash	❑ Flushing	❑ Swelling (face, arms, hands, legs)
Mouth:	❑ Itching	❑ Swelling (lips, tongue, mouth)			
Abdominal:	❑ Nausea	❑ Cramps	❑ Vomiting	❑ Diarrhea	
Throat:	❑ Itching	❑ Tightness	❑ Hoarseness	❑ Cough	
Lungs:	❑ Shortness of breath		❑ Repetitive Cough		❑ Wheezing
Heart:	❑ Weak pulse	❑ Loss of consciousness			

4. Treatment

a. How have past reactions been treated? _____
b. How effective was the student's response to treatment? _____
c. Was there an emergency room visit? ❑ No ❑ Yes, explain: _____
d. Was the student admitted to the hospital? ❑ No ❑ Yes, explain: _____
e. What treatment or medication has your healthcare provider recommended for use in an allergic reaction?
_____
f. Has your healthcare provider provided you with a prescription for medication? ❑ No ❑ Yes
g. Have you used the treatment or medication? ❑ No ❑ Yes
h. Please describe any side effects or problems your child had in using the suggested treatment: _____
_____

5. Self Care

a. Is your student able to monitor and prevent their own exposures? ❑ No ❑ Yes
b. Does your student:
   1. Know what foods to avoid ❑ No ❑ Yes
   2. Ask about food ingredients ❑ No ❑ Yes
   3. Read and understands food labels ❑ No ❑ Yes
   4. Tell an adult immediately after an exposure ❑ No ❑ Yes
   5. Wear a medical alert bracelet, necklace, watchband ❑ No ❑ Yes
   6. Tell peers and adults about the allergy ❑ No ❑ Yes
   7. Firmly refuses a problem food ❑ No ❑ Yes
c. Does your child know how to use emergency medication? ❑ No ❑ Yes _____
d. Has your child ever administered their own emergency medication? ❑ No ❑ Yes _____

6. Family / Home

a. How do you feel that the whole family is coping with your student's food allergy? _____
b. Does your child carry epinephrine in the event of a reaction? ❑ No ❑ Yes
c. Has your child ever needed to administer that epinephrine? ❑ No ❑ Yes
d. Do you feel that your child needs assistance in coping with his/her food allergy? _____

7. General Health

a. How is your child's general health other than having a food allergy? _____
b. Does your child have other health conditions? _____
c. Hospitalizations? _____
d. Does your child have a history of asthma? ❑ No ❑ Yes
   If yes, does he/she have an Asthma Action Plan? ❑ No ❑ Yes
e. Please add anything else you would like the school to know about your child's health: _____
   _____

8. Notes:

Parent / Guardian Signature: _____ **Date:** _____

Reviewed by R.N.: _____ **Date:** _____

Adapted with permission – Washington State Guidelines for Anaphylaxis

American Academy of Allergy Asthma & Immunology
www.aaaai.org

Anaphylaxis Emergency Action Plan

Patient Name: _____ **Age:** _____

Allergies: _____

Asthma ☐ **Yes** ***(high risk for severe reaction)*** ☐ **No**

Additional health problems besides anaphylaxis: _____

_____

Concurrent medications: _____

_____

Symptoms of Anaphylaxis

MOUTH	**itching, swelling of lips and/or tongue**
THROAT*	**itching, tightness/closure, hoarseness**
SKIN	**itching, hives, redness, swelling**
GUT	**vomiting, diarrhea, cramps**
LUNG*	**shortness of breath, cough, wheeze**
HEART*	**weak pulse, dizziness, passing out**

Only a few symptoms may be present. Severity of symptoms can change quickly.
****Some symptoms can be life-threatening. ACT FAST!***

Emergency Action Steps - DO NOT HESITATE TO GIVE EPINEPHRINE!

1. Inject epinephrine in thigh using (check one):

☐ **Adrenaclick (0.15 mg)** ☐ **Adrenaclick (0.3 mg)**

☐ **Auvi-Q (0.15 mg)** ☐ **Auvi-Q (0.3 mg)**

☐ **EpiPen Jr (0.15 mg)** ☐ **EpiPen (0.3 mg)**

Epinephrine Injection, USP Auto-injector- authorized generic
☐ **(0.15 mg)** ☐ **(0.3 mg)**

☐ **Other (0.15 mg)** ☐ **Other (0.3 mg)**

Specify others: _____

IMPORTANT: ASTHMA INHALERS AND/OR ANTIHISTAMINES CAN'T BE DEPENDED ON IN ANAPHYLAXIS.

2. Call 911 or rescue squad (before calling contact)

3. Emergency contact #1: home_____ **work**_____ **cell**_____

Emergency contact #2: home_____ **work**_____ **cell**_____

Emergency contact #3: home_____ **work**_____ **cell**_____

Comments: _____

_____

_____
Doctor's Signature/Date/Phone Number

_____
Parent's Signature (for individuals under age 18 yrs)/Date

Certificate of Immunization Status (CIS)

Reviewed by:	Date:
Signed COE on File? ☐ Yes ☐ No	

Please print. See back for instructions on how to fill out this form or get it printed from the Washington State Immunization Information System.

Child's Last Name:	**First Name:**	**Middle Initial:**	**Birthdate (MM/DD/YYYY):**

I give permission to my child's school/child care to add immunization information into the Immunization Information System to help the school maintain my child's record.	Conditional Status Only: I acknowledge that my child is entering school/child care in conditional status. For my child to remain in school, I must provide required documentation of immunization by established deadlines. See back for guidance on conditional status.
X _____ **Parent/Guardian Signature** **Date**	X _____ **Parent/Guardian Signature Required if Starting in Conditional Status** **Date**

▲Required for School ● Required Child Care/Preschool	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY
Required Vaccines for School or Child Care Entry						
●▲ DTaP (Diphtheria, Tetanus, Pertussis)						
▲ Tdap (Tetanus, Diphtheria, Pertussis) (grade 7+)						
●▲ DT or Td (Tetanus, Diphtheria)						
●▲ Hepatitis B						
● Hib (*Haemophilus influenzae type b*)						
●▲ IPV (Polio) (any combination of IPV/OPV)						
●▲ OPV (Polio)						
●▲ MMR (Measles, Mumps, Rubella)						
● PCV/PPSV (Pneumococcal)						
●▲ Varicella (Chickenpox) ☐ History of disease verified by IIS						
Recommended Vaccines (Not Required for School or Child Care Entry)						
Flu (Influenza)						
Hepatitis A						
HPV (Human Papillomavirus)						
MCV/MPSV (Meningococcal Disease types A, C, W, Y)						
MenB (Meningococcal Disease type B)						
Rotavirus						

Documentation of Disease Immunity (Health care provider use only)

If the child named in this CIS has a history of varicella (chickenpox) disease or can show immunity by blood test (titer), it must be verified by a health care provider.

I certify that the child named on this CIS has:
☐ A verified history of varicella (chickenpox) disease.
☐ Laboratory evidence of immunity (titer) to disease(s) marked below.

☐ Diphtheria	☐ Hepatitis A	☐ Hepatitis B
☐ Hib	☐ Measles	☐ Mumps
☐ Rubella	☐ Tetanus	☐ Varicella

☐Polio (all 3 serotypes must show immunity)

►

Licensed Health Care Provider Signature Date

►

Printed Name

I certify that the information provided on this form is correct and verifiable.

Health Care Provider or School Official Name: _____ Signature: _____ Date:_____
If verified by school or child care staff the medical immunization records must be attached to this document.

Instructions for completing the Certificate of Immunization Status (CIS): Print the from the Immunization Information System (IIS) or fill it in by hand.

To print with the immunization information filled in:
Ask if your health care provider's office enters immunizations into the WA Immunization Information System (Washington's statewide registry). If they do, ask them to print the CIS from the IIS and your child's immunization information will fill in automatically. You can also print a CIS at home by signing up and logging into MyIR at https://wa.myir.net. If your provider doesn't use the IIS, email or call the Department of Health to get a copy of your child's CIS: waiisrecords@doh.wa.gov or 1-866-397-0337.

To fill out the form by hand:
1. Print your child's name and birthdate, and sign your name where indicated on page one.
2. Write the date of each vaccine dose received in the date columns (as MM/DD/YY). If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guides below to record each vaccine correctly. For example, record Pediatix under Diphtheria, Tetanus, Pertussis as DTaP, Hepatitis B as Hep B, and Polio as IPV.
3. If your child had chickenpox (varicella) disease and not the vaccine, a health care provider must verify chickenpox disease to meet school requirements.
   - ☐ If your health care provider can verify that your child had chickenpox, ask your provider to check the box in the Documentation of Disease Immunity section and sign the form.
   - ☐ If school staff access the IIS and see verification that your child had chickenpox, they will check the box under Varicella in the vaccines section.
4. If your child can show positive immunity by blood test (titer), have your health care provider check the boxes for the appropriate disease in the Documentation of Disease Immunity section, and sign and date the form. You must provide lab reports with this CIS.
5. Provide proof of medically verified records, following the guidelines below.

Acceptable Medical Records
All vaccination records must be medically verified. Examples include:

- A Certificate of Immunization Status (CIS) form printed with the vaccination dates from the Washington State Immunization Information System (IIS), MyIR, or another state's IIS.
- A completed hardcopy CIS with a health care provider validation signature.
- A completed hardcopy CIS with attached vaccination records printed from a health care provider's electronic health record with a health care provider signature or stamp. The school administrator, nurse, or designee must verify the dates on the CIS have been accurately transcribed and provide a signature on the form.

Conditional Status
Children can enter and stay in school or child care in conditional status if they are catching up on required vaccines for school or child care entry. (Vaccine series doses are spread out among minimum intervals, so some children may have to wait a period of time before finishing their vaccinations. This means they may enter school while waiting for their next required vaccine dose). To enter school or child care in conditional status, a child must have all the vaccine doses they are eligible to receive before starting school or child care.

Students in conditional status may remain in school while waiting for the minimum valid date of the next vaccine dose plus another 30 days time to turn in documentation of vaccination. If a student is catching up on multiple vaccines, conditional status continues in a similar manner until all of the required vaccines are complete.

If the 30-day conditional period expires and documentation has not been given to the school or child care, then the student must be excluded from further attendance, per RCW 28A.210.120. Valid documentation includes evidence of immunity to the disease in question, medical records showing vaccination, or a completed certificate of exemption (COE) form.

Reference guide for vaccine trade names in alphabetical order For updated list, visit https://www.cdc.gov/vaccines/terms/usvaccines.html

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB	Hib	Fluarix	Flu	Havrix	Hep A	Menveo	Meningococcal	Rotarix	Rotavirus (RV1)
Adacel	Tdap	Flucelvax	Flu	Hiberix	Hib	Pediarix	DTaP + Hep B + IPV	RotaTeq	Rotavirus (PV5)
Afluria	Flu	FluLaval	Flu	HibTITER	Hib	PedvaxHIB	Hib	Tenivac	Td
Bexsero	MenB	FluMist	Flu	Ipol	IPV	Pentacel	DTaP + Hib +IPV	Trumenba	MenB
Boostrix	Tdap	Fluvirin	Flu	Infanrix	DTaP	Pneumovax	PPSV	Twinrix	Hep A + Hep B
Cervarix	2vHPV	Fluzone	Flu	Kinrix	DTaP + IPV	Prevnar	PCV	Vaqta	Hep A
Daptacel	DTaP	Gardasil	4vHPV	Menactra	MCV or MCV4	ProQuad	MMR + Varicella	Varivax	Varicella
Engerix-B	Hep B	Gardasil 9	9vHPV	Menomune	MPSV4	Recombivax HB	Hep B		

If you have a disability and need this document in another format, please call 1-800-525-0127 (TDD/TTY call 711).

DOH 348-013 November 2019