Child Care Registration Form

Date child entered care	Date child left care

Child's name (Last, First, Middle)	Name used (Nickname)	Birthdate
Street address	City	Zip code

Child's parent/guardian name	Circle the best number to contact you at when your child is in our care		
	cell phone #	home phone #	alternate phone #
Street address	City		Zip code

Child's parent/guardian name	Circle the best number to contact you at when your child is in our care		
	cell phone #	home phone #	alternate phone #

I give my permission for any of the following individuals to be contacted and my child may be released to any of them.

Parent/Guardian signature: _____ *Date:* _____

In an emergency, if you are not able to contact me, contact the following:

Name (first and last)	cell phone #	home phone #	alternative phone #

These individuals also have permission to pick up my child:

Name (first and last)	cell phone #	home phone #	alternative phone #

Child's health information

Child's medical care provider or parent's/guardian's preferred medical facility for treatment Name: Phone: Street Address:	Child's last physical exam, if available
Child's dental care provider or parent's/guardian's preferred dental facility for treatment Name: Phone: Street Address:	Child's last dental exam, if available

Known health conditions (An individual care plan from child's health care provider is required for any food allergies or special dietary requirement due to a health condition.)

Consent to medical care and treatment of minor children			
I give permission that my child, _____ may be given first aid/emergency treatment by the child care licensee and or qualified staff at: Name of Licensee: _____ Address of Licensee: _____			
Parent/guardian signature	Date	Parent/guardian signature	Date
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 or advisable by the physician or aid care attendant to safeguard my child's health. I waive my right of informed consent to such treatment. I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment. I certify under penalty of perjury under the laws of the State of Washington that this information is true and correct.			
Parent/guardian signature	Date	Parent/guardian signature	Date

CHILD CARE AGREEMENT

First	Middle	Last
Child's name:		
Parent or Guardian name:		

Days and times my child will receive care:

Check days of care	☐ Sunday	☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday	☐ Saturday
Arrival time							
Departure time							

FEE: $_____ per:
☐ Hour
☐ Day
☐ Week
☐ Month

Date payment due:

Source of payment:
☐ Parent
☐ Other (specify):

Overtime rate: $ per:

Late fee: $ per:

I agree to promptly notify the child care provider of any changes of the above information. I understand that I am fully responsible for the terms of this agreement as stipulated.

I have read, understand and agree to comply with the policy and procedures and information for parents given to me by:

Name of Licensee

Parent or guardian signature	Date	Parent or guardian signature	Date

I agree to provide child care services according to the above plan. I agree to promptly notify the parents or guardians of any changes to above information.

Licensee signature Date

Street Address City State Zip code

Comments

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	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	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)						
COVID-19						
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 Pediarix 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 June 2021**

Child Care Injury/Incident Report

Child's Name:

In addition to reporting to the department by phone or email about the following incidents and injuries, a provider must also complete this incident report and submit it to DCYF within 24-hours.

Provider Name			Provider ID
Child's Age	Date of Incident	Time of Incident ☐ a.m. ☐ p.m.	Incident Occurred ☐ Indoors ☐ Outdoors
List names of staff present and/or witnesses:		Treatment provided to child while in care & by who:	

Check All That Apply

Situation that required an emergency response from:

☐ Emergency services (911) 110-300-0475(2)(b)/110-301-0475(2)(b)

☐ Washington poison center 110-300-0475(2)(c)/110-301-0475(2)(c)

☐ Department of Health 110-300-0475(2)(d)/110-301-0475(2)(d)

Situations that occur while children are in care that may put children at risk including, but not limited to:

☐ Inappropriate sexual touching ☐ Physical abuse ☐ Neglect ☐ Maltreatment ☐ Exploitation

☐ Other

Serious injury to a child in care:

☐ Severe bleeding	☐ One or more fractured/broken bones	☐ Choking or serious unexpected breathing problems
☐ Severe neck/head injury	☐ Sudden unconsciousness	☐ Dangerous chemicals in eyes, on skin, or ingested
☐ Near drowning	☐ Shock or acute confused state	☐ Severe burn requiring professional medical care
☐ Poisoning	☐ Overdose of chemical substance	☐ Injury resulting in overnight hospital stay

Please give a brief description of the injury/incident, including where it occurred.

Parent/Guardian Contacted	Licensor Contacted
Date: Time: ☐ In Person ☐ Phone ☐ E-mail	Date: Time: ☐ In Person ☐ Phone ☐ E-mail

Parent/Guardian Comments:

Parent/Guardian Signature Date *By signing this form, I acknowledge that I received a copy of this report.*	Licensee/Staff Signature Date

Child Care Medication Log

Child's Name (first and last):			
Name of Medication (as it is appears on medication container):			
**** If a medication was not given, you must document the reason why. ****			
Date	Time	Dosage	Side Effects Observed (if any)
Name of person who gave medication: ____________ *(print name)* ____________ *(signature)*			
Date	Time	Dosage	Side Effects Observed (if any)
Name of person who gave medication: ____________ *(print name)* ____________ *(signature)*			
Date	Time	Dosage	Side Effects Observed (if any)
Name of person who gave medication: ____________ *(print name)* ____________ *(signature)*			
Date	Time	Dosage	Side Effects Observed (if any)
Name of person who gave medication: ____________ *(print name)* ____________ *(signature)*			
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Name of person who gave medication: ____________ *(print name)* ____________ *(signature)*			
Date	Time	Dosage	Side Effects Observed (if any)
Name of person who gave medication: ____________ *(print name)* ____________ *(signature)*			
Date	Time	Dosage	Side Effects Observed (if any)
Name of person who gave medication: ____________ *(print name)* ____________ *(signature)*			
Date	Time	Dosage	Side Effects Observed (if any)
Name of person who gave medication: ____________ *(print name)* ____________ *(signature)*			

Child Care Medication Authorization Form

An early learning or school-age provider must not give medication to any child without written and signed consent from that child's parent or guardian, must administer medication pursuant to directions on the medication label, and must use appropriate cleaned and sanitized medication measuring devices.

Child's full name (first and last):		Child's Birthdate:
Name of Medication (as it appears on medication container):		
Dosage:	Start Date:	End Date:
To be given at the following times:		
Reason for Giving Medication to Child/Medical Need:		
Possible Side Effects of Medication:		
Additional Information:		

Prescription medication must only be given to the child named on the prescription. Prescription medication must be labeled with: child's first and last name, the date the prescription was filled, the name and contact information of the prescribing health professional, the expiration date, dosage amount, length of time to give the medication, and instructions for administration and storage.

Nonprescription (over-the-counter) medication must be brought to the early learning or school-age program by the child's parent or guardian in the original packaging with expiration date and labeled with the child's first and last name. It must only be given to the child named on the label provided by the parent or guardian. Instructions on the label must be followed, unless the parent or guardian provides a medical professional's note.

If the packaging label does not include expiration date, dosage amount, age, and length of time to give the medication, then written authorization from a health care provider with prescriptive authority is required, as well as the written and signed consent from the child's parent or guardian. This includes: vitamins, herbal supplements, fluoride supplements, homeopathic or naturopathic medication, and teething gels or tablets (amber bead necklaces are prohibited).

I hereby give permission for the staff of _____ to give my child the medication as prescribed above.
(name of early learning or School age provider/program)

_____ _____
Parent/Guardian Signature *Date*

This section to be completed by child's parent or guardian, if applicable:
I, or my appointed designee, have provided training about specialized medication administration procedures for my child specific to this medication to the following staff member(s):_____

_____ _____
Parent/Guardian (or Designee) Signature Date *Early Learning or School-ageProvider Signature Date*

Daily Child Attendance Record for Child Care Facilities

Shaded section for child care staff use when child leaves and returns to licensee's care								Month and Year	
Date	**Child's Name (First/Last)**	**Time in**	**Parent/guardian or authorized person signature**	**Time out**	**Staff signature**	**Time in**	**Staff signature**	**Time out**	**Parent/guardian or authorized person signature**