DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Children and Family Services
CFS-62 (Rev. 01/2005)

BEAR BUDDIES EDUCATIONAL RESOURCES, INC.

STATE OF WISCONSIN

CHILD CARE ENROLLMENT

Use of form: Use of this form is mandatory for Family Child Care Centers to comply with HFS 45.04(6)(a)1. Failure to comply may result in issuance of a noncompliance statement. This form may also be used by Group Child Care Centers, Day Camps, and certified Day Care Homes to comply with HFS 46.04(6)(a)1., HFS 55.41(4)(a)1. and DWD 55.08(12)(f) respectively. Personally identifiable information gathered on this form will be used only to verify compliance with the above-mentioned rules.

Instructions: The parent / guardian shall complete this form and submit it to the center prior to the child's first day of attendance. Information on this form shall be kept current. **Licensed Child Care Centers:** If child is under two years of age, CFS-61, Intake for Child Under 2 Years, must also be completed prior to the child's first day of attendance.

CHILD INFORMATION

Name (Last, First, MI)	Address – Home (Street, City, State, Zip)	Telephone Number	Birthdate (mm/dd/yyyy)	First Day of Attendance

PARENT OR GUARDIAN – All parents / guardians are permitted to visit during center hours and are allowed to pick up the child unless access is prohibited or restricted by a court order. Attach court order, if any.

Relationship to Child	Name	Address – Home (Street, City, State, Zip)	Home / Cell Telephone No.	Name and Address – Place of Employment OR Where Reachable While Child is in Care	Telephone No.
Mother					
Father					
Guardian					
Guardian					

PERSONS OTHER THAN PARENTS / GUARDIANS WHO ARE AUTHORIZED TO PICK UP CHILD – Provide information requested for each person. If no one, write "None."

Relationship to Child	Name	Address – Home (Street, City, State, Zip)	Home / Cell Telephone No.	Name and Address – Place of Employment OR Where Reachable While Child is in Care	Telephone No.

EMERGENCY CONTACT – Provide information for the person to contact when parents / guardians cannot be reached.
☐ Yes ☐ No This person is authorized to pick up the child.

Relationship to Child	Name	Address – Home (Street, City, State, Zip)	Home / Cell Telephone No.	Name and Address – Place of Employment OR Where Reachable While Child is in Care	Telephone No.

PHYSICIAN OR MEDICAL FACILITY

Name	Address	Telephone Number

AUTHORIZATION

☐ Yes ☐ No I hereby give my consent for emergency medical care or treatment to be used only if I cannot be reached immediately.

☐ Yes ☐ No I have had an opportunity to review the policies of this child care center and a summary of the Wisconsin Rules for Licensing Child Care Centers.

☐ Yes ☐ No I give permission for my child to participate in field trips and other activities during operating hours. ☐ Transported ☐ Walking

☐ Yes ☐ No I have been informed of the number of pets in the center and their degree of contact with the enrolled children. Note: If pets are added after a child is enrolled, parents shall be notified in writing prior to the pet's addition to the center.

SIGNATURE – Parent or Guardian	Date Signed

EMAIL ADDRESS: MOM_____ DAD:_____

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Children and Family Services
CFS-2345 (Rev. 07/2005)

STATE OF WISCONSIN

HEALTH HISTORY AND EMERGENCY CARE PLAN

Use of form: This form is required for family and group child care centers to comply with HFS 45.04(6)(a)1., 45.07(6)(L)5., 46.07(6)(k)5., and 46.04(6)(a)6. of the Wisconsin Administrative Codes. Failure to comply may result in issuance of a noncompliance statement. This form may also be used by day camps to ensure compliance with HFS 55.44(6)(g). Personally identifiable information gathered on this form will be used only to verify compliance with licensing rules.

Instructions: The parent / guardian should complete this form for placement in the child's file prior to the child's first day of attendance. A periodic review by parents / guardians and staff is recommended. Information contained on the form shall be shared with any person caring for the child.

CHILD INFORMATION

Name (Last, First, MI)	Address – Home (Street, City, State, Zip Code)	
Telephone Number	Birthdate (mm/dd/yyyy)	Date – First Day of Attendance (mm/dd/yyyy)

PARENT / GUARDIAN INFORMATION Provide information where the parent(s) / guardian(s) may be reached while the child is in care.

Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular
Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular

PHYSICIAN / MEDICAL FACILITY INFORMATION

Name – Physician	Address – Medical Facility	Telephone Number

1. Check any special medical condition that your child may have.
   - ☐ No specific medical condition
   - ☐ Asthma ☐ Diabetes ☐ Epilepsy / seizure disorder ☐ Gastrointestinal or feeding concerns including special diet and supplements
   - ☐ Cerebral palsy / motor disorder ☐ Emotional / behavior disorder including ADD or ADHD
   - ☐ Other condition(s) requiring special care – Specify.

   - ☐ Food allergies – Specify food(s).

   - ☐ Non-food allergies – Specify.

2. Triggers that may cause problems – Specify.

3. Signs or symptoms to watch for – Specify.

4. Steps the child care provider should follow. If medications are necessary, a copy of the CFS-59, Authorization to Administer Medication, should be attached to this form. (Note: Group Child Care Centers and Day Camps may use their own form.) Indicate any child care staff who have received specialized training / instructions to help treat symptoms.

   a.

   b.

   c.

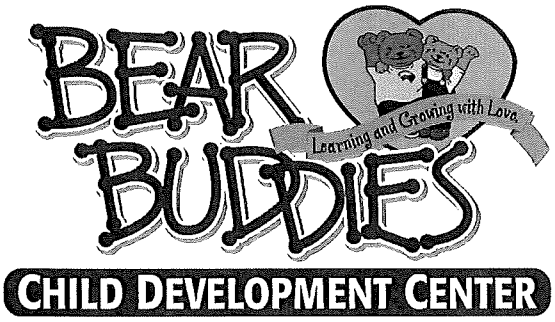
5. When to call parents regarding symptoms or failure to respond to treatment.

6. When to consider that the condition requires emergency medical care or reassessment.

7. Additional information that may be helpful to the child care provider.

SIGNATURE – Parent or Guardian	Date Signed

Review dates: _____ _____ _____ _____ _____



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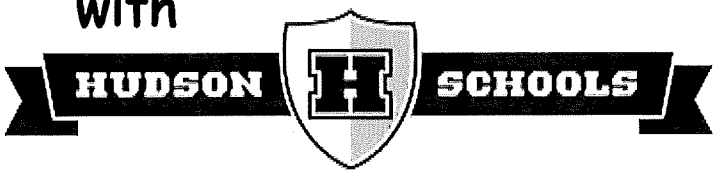


(Sponsored by Bear Buddies Educational Resources, Inc.)

PARENT ORIENTATION CHECK LIST
2019-2020

I (we) agree to comply with its policies as outlined below.
PLEASE INITIAL EACH LINE ITEM

*** **Tuition:**

_____ I (we) understand that there is NO FEE for the Hudson 4K Program.

_____ I (we) understand that drop off and pick up times are no earlier or later than 5 minutes before and after school hours.

_____ I (we) understand that I will be charged a rate of $5 up to the first 15 minutes (payable in ½ hour increments) an hourly rate of $9.50 per hour for any times other than the allotted preschool hours. This is including early arrival and late pick up. Fees are due at time of pick up.

*** **Health:**

_____ I (we) agree to provide Bear Buddies current immunization and health records prior to attendance in accordance with Wisconsin State Licensing.

_____ I (we) agree to pick up my child within one hour of being notified of a condition or illness that warrants exclusion from preschool.

_____ I (we) agree to inform Bear Buddies of any health information concerning allergies, immunizations, communicable disease, diet or other special needs.

*** **Curriculum:**

_____ I (we) understand that my child will receive a daily educational program that includes, but is not limited to, activities in cognitive development (pre-reading, pre-math, thought processes), communication (expressive and receptive), motor development, language development, character growth (socialization, conflict resolution, positive self image).

_____ I (we) understand that weekly lesson plans, weekly newsletters and a daily classroom schedule will be given to me, e-mailed or posted in the classroom for me to view.

*** **Communication:**

_____ I (we) agree to inform the staff and office of changes in persons authorized to drop off or pick up my child.

_____ I (we) understand that any **authorized** person picking up my child will be required to have a picture I.D.

_____ I (we) agree to share with the preschool teacher and/or director any concerns regarding the type or quality of education my child receives, both positive and constructive.

_____ I (we) acknowledge that regular communication with my child's teacher can be expected including but not limited to daily personal communication and parent conferences with progress reports.

_____ I (we) acknowledge that 2 conferences will be held throughout the year. One will be scheduled in the fall and one in spring. They will be up to ½ hour each.

*** **Parent Involvement:**

_____ I (we) understand that the parent involvement activities are offered as part of the Hudson 4K program to enhance school, community and family unity. These are not required attendance and may involve a small fee.

*** **Scheduled Time:**

_____ My child's normal schedule is AM or PM (circle one)

*** **Waiver:**

_____ I (we) understand that accidents happen when children play and grow and in the event that a non-negligent accident occurs due to play or child on child, I (we) will not hold Bear Buddies Child Development Center INC. responsible.

_____ I (we) understand that by singing this contract, I (we) agree to waive any and all claims, demands, suits and charges that I (we) have or may have in the future in connection with Bear Buddies Child Development Center, INC., its officers, trustees, agents, and employees; including but not limited to personal injury, bodily harm, injury or property damage occurring while my child is in their care.

_____ I (we) understand that by singing this contract I (we) agree to HOLD HARMLESS and INDEMNIFY Bear Buddies Child Development Center, INC., for any and all liability for any property damage, loss or personal injury to any third party.

_____ _____

Parent Signature Date

_____ _____

Parent Signature Date

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-04020L (Rev. 07/12)

STATE OF WISCONSIN
252.04 and 120.12 (16) Wis. Stats.

STUDENT IMMUNIZATION RECORD

INSTRUCTIONS TO PARENT: COMPLETE AND RETURN TO SCHOOL WITHIN **30 DAYS AFTER ADMISSION.** State law requires all public and private school students to present written evidence of immunization against certain diseases **within 30 school days of admission.** The current age/grade specific requirements are available from schools and local health departments. These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the school. The purpose of this form is to measure compliance with the law and will be used for that reason only. If you have questions on immunizations or how to complete this form, contact your child's school or local health department.

Step 1 PERSONAL DATA — PLEASE PRINT

Student's Name	Birthdate (Mo/Day/Yr)	Gender	School	Grade	School Year

Name of Parent/Guardian/Legal Custodian	Address (Street, City, State, Zip)	Telephone Number ( )

Step 2 IMMUNIZATION HISTORY

List the MONTH, DAY AND YEAR your child received each of the following immunizations. DO NOT USE A (√) OR (X) except to answer the question about chickenpox, Tdap or Td. If you do not have an immunization record for this student at home, contact your doctor or public health department to obtain it.

TYPE OF VACCINE*	FIRST DOSE Mo/Day/Yr	SECOND DOSE Mo/Day/Yr	THIRD DOSE Mo/Day/Yr	FOURTH DOSE Mo/Day/Yr	FIFTH DOSE Mo/Day/Yr
DTaP/DTP/DT/Td (Diphtheria, Tetanus, Pertussis)					
Adolescent booster (Check appropriate box) ☐ Tdap ☐ Td					
Polio					
Hepatitis B					
MMR (Measles, Mumps, Rubella)					
Varicella (Chickenpox) Vaccine Vaccine is required only if your child has not had chickenpox disease. See below:					

Has your child had Varicella (chickenpox) disease? Check the appropriate box
And provide the year if known:
☐ YES _____ year (Vaccine not required)
☐ NO or Unsure (Vaccine required)

Step 3 REQUIREMENTS

Refer to the age/grade level requirements for the current school year to determine if this student meets the requirements.

Step 4 COMPLIANCE DATA

STUDENT MEETS ALL REQUIREMENTS
Sign at Step 5 and return this form to school.

Or

STUDENT DOES NOT MEET ALL REQUIREMENTS

Check the appropriate box below, sign at Step 5, and return this form to school. PLEASE NOTE THAT INCOMPLETEY IMMUNIZED STUDENTS MAY BE EXCLUDED FROM SCHOOL IF AN OUTBREAK OF ONE OF THESE DISEASES OCCURS.

☐ Although my child has NOT received ALL required doses of vaccine, the FIRST DOSE(S) has/have been received. I understand that the SECOND DOSE(S) must be received by the 90th school day after admission to school this year, and that the THIRD DOSE(S) and FOURTH DOSE(S) if required must be received by the 30th school day next year. I also understand that it is my responsibility to notify the school in writing each time my child receives a dose of required vaccine.

NOTE: **Failure to stay on schedule and notify the school may result in court action and a fine of up to $25.00 per day of violation.**

WAIVERS (List in Step 2 above, the date(s) of any immunizations your child has already received)

☐ **For health reasons** this student should not receive the following immunizations _____

_____ _____
SIGNATURE - Physician Date Signed

☐ **For religious reasons** this student should not be immunized.

☐ **For personal conviction reasons** this student should not be immunized.

_____
LIST VACCINE(S) WAIVED

Step 5 SIGNATURE

This form is complete and accurate to the best of my knowledge. Check one: (I do☐ I do not☐) give permission to share my child's current immunization records and as they are updated in the future with the Wisconsin Immunization Registry (WIR). I understand that I may revoke this consent at any time by sending written notification to the school district. Following the date of revocation, the school district will provide no new records or updates to the WIR.

_____ _____
SIGNATURE - Parent/Guardian/Legal Custodian or Adult Student Date Signed

Clear Form

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

dcf.wisconsin.gov/

CHILD HEALTH REPORT – CHILD CARE CENTERS

Use of form: Use of this form is voluntary; however, completion of this form meets the requirements of DCF 202.08(4), DCF 250.07(6)(L)3., and DCF 251.07(6)(k)3. Failure to comply with these rules may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: Each child under 2 years of age shall have an initial health examination not more than 6 months prior to nor later than 3 months after being admitted to the center and a follow-up health examination at least once every 6 months thereafter. Except for a school-aged child, each child 2 years of age or older shall have an initial health examination not more than one year prior to nor later than 3 months after being admitted to a center and a follow-up health examination at least once every 2 years thereafter. The parent / guardian shall give this form to the physician, physician assistant or HealthCheck provider to be completed, signed and dated. The licensee shall obtain a copy for the child's record. Note: Children are also required to have on file at the child care center documentation of immunizations; it may be helpful if the parent / guardian were to include a copy of the child's immunization record when submitting this form to the child care center.

PARENT OR GUARDIAN – Complete this section.

Name – Child (Last, First, MI)	Birthdate – Child (mm/dd/yyyy)

Address – Child (Street, City, State, Zip Code)

Name – Parent or Guardian (Last, First, MI)

Address – Parent or Guardian (Street, City, State, Zip Code)

HEALTH PROFESSIONAL – Complete this section.

Instructions for feeding and care of child with special problems, including allergies – Specify (attach information as necessary).

☐ Yes ☐ No Does the child have a milk allergy? If "Yes", identify the recommended milk substitute.

Date of most recent blood lead test: _____ (mm/dd/yyyy). Note: Children on Medicaid are required to be tested at around ages 12 months and 24 months or once between the ages of 3 and 5 years if no previous test is documented. Lead testing is optional for children who are not on Medicaid.

Immunization(s) not to be administered to child due to medical reason(s) – Specify.

AUTHORIZATION

I certify that I have examined the above child on this date and that he / she is able to participate in child care activities.

Name – MD, PA or HealthCheck Provider (type or print)	Address (Street, City, State, Zip Code)

SIGNATURE – MD, PA or HealthCheck Provider	Date of Examination

HOUSEHOLD SIZE—INCOME STATEMENT

Child and Adult Care Food Program

An adult household member must complete this form (HSIS) and return it to the center. Complete one HSIS per household.
Refer to the accompanying *Household Letter* for instructions on completing this form.

First and Last Name(s) of Enrolled Child(ren)	Center
	BBCDC - Hudson

PART 1: BENEFITS

If no one receives these benefits, skip to PART 2.

If any member of your household currently receives benefits from: Check the box for the benefit received AND list the case number

- FoodShare Wisconsin (10 digit #) ☐ __ __ __ __ __ __ __ __ __ __
- Wisconsin Works (W-2) Cash Assistance (10 digit #) ☐ __ __ __ __ __ __ __ __ __ __
- FDPIR (9 digit #) ☐ __ __ __ __ __ __ __ __ __

• DO NOT list a 16 digit Quest Card number for FoodShare
• Wisconsin Shares Child Care Subsidy benefits is NOT W-2 Cash Assistance.

PART 2: TOTAL HOUSEHOLD SIZE AND INCOME (Complete a, b, and c)

If you completed PART 1, you do not need to list household and income information below.

a) List full names of all household members below, including yourself and all children.

Household Member: anyone who is living with you and shares income and expenses, even if not related.

b) List all income on the same line as the person who receives it.
- Record each income source only once.
- Check the box for how often each income source is received.

Household Members	(Optional) Age	Check if Foster Child	Check if No Income	Gross wages, Net income (self-employed), Commission, Tips, Cash bonuses, Military pay & allowances for off-site housing/food/clothing, Work comp, strike ben., Unemployment	Weekly	Every 2 Weeks	Twice per Month	Monthly	Annually	Pensions, Retirement Social Security, VA benefits, SSI, Disability, Child Support, Adoption assistance, Alimony	Weekly	Every 2 Weeks	Twice per Month	Monthly	Annually	Private pensions, Trusts/estates, Annuities, Investments, Interest, Net rental income, Savings withdrawals, Any other income	Weekly	Every 2 Weeks	Twice per Month	Monthly	Annually
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐

c) Record total # of household members: ______

PART 3: ALL HOUSEHOLDS

ETHNICITY AND RACE DATA COLLECTION – *Completion is optional*

This center is required by Federal law to ask the following two questions concerning ethnicity and race. Your answers are strictly for statistical reporting and will have no effect on determination of eligibility for benefits. Please answer both questions.

IS YOUR CHILD(REN) HISPANIC OR LATINO? ☐ Yes, Hispanic or Latino ☐ No, neither Hispanic nor Latino

SELECT ONE OR MORE OF THE FOLLOWING CATEGORIES THAT APPLY TO YOUR CHILD(REN):
☐ American Indian or Alaska Native ☐ Black or African American ☐ White ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

ADULT HOUSEHOLD MEMBER SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (SS#)

If Part 2 is completed, the adult signing the form must list the last four digits of his/her SS# OR check "None" if he/she does not have a SS#.

I CERTIFY (promise) that all information on this form is true, and that all income is reported unless eligibility is established by receiving FoodShare, W-2 Cash Assistance, and/or FDPIR. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws.

Signature of Adult Household Member	Signature Date *Mo./Day/Yr.*	Last 4 digits of SS# (or check "None" if you do not have a SS#) ***-**-__ __ __ __ ☐ None

FOR CENTER USE ONLY – Complete all 3 sections and the *Effective Month of Determination*

Section 1: Basis of Determining Eligibility *(A or B)*

A. *Household Size & Income*
Total Household Size ______
*Total Income $________/______
($ Amount) (Time Period)

B. *Benefits/Foster*
☐ FoodShare WI
☐ W-2 Cash Assistance
☐ FDPIR
☐ Foster Child(ren)

Section 2: Eligibility Determination
☐ Free
☐ Reduced
☐ Non-Needy

Section 3: Determining Official's Initials & Approval Date
____

**Effective Month of Determination
____
Month/Year

*Convert to yearly income only when multiple pay frequencies are reported, using only these multipliers:

Weekly x 52	Twice a month x 24
Every 2 weeks x 26	Monthly x 12

**This form expires one year from the *Effective Month of Determination.*

Wisconsin Department of Public Instruction
CACFP ENROLLMENT FORM
PI-6077 (Rev. 02-17)

Parent/Guardian Instructions:

Use a separate form for each enrolled child. In the spaces below list the child's name, current age, the days and hours normally in care, and the meals normally received while in care. If the child is of school age report the hours in care both before and after school. Child and Adult Care Food Program (CACFP) regulations require that the enrollment form be updated annually and signed by the child's parent or guardian. **This form can be used for three years for the same child, to meet the annual updating requirements.**

GENERAL INFORMATION

Child's Name	Child Care Facility	Child's Age
	BBCDC - Hudson	

HOURS AND MEALS WHILE IN CARE

Days Normally in Care (Check ✓)	Hours Normally in Care				Meals Normally Received While in Care (Check ✓)					
	From	To	From	To	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
☐ Sunday					☐	☐	☐	☐	☐	☐
☐ Monday					☐	☐	☐	☐	☐	☐
☐ Tuesday					☐	☐	☐	☐	☐	☐
☐ Wednesday					☐	☐	☐	☐	☐	☐
☐ Thursday					☐	☐	☐	☐	☐	☐
☐ Friday					☐	☐	☐	☐	☐	☐
☐ Saturday					☐	☐	☐	☐	☐	☐

Additional Information

Signature of Parent/Guardian ➢	Date Signed *Mo./Day/Yr.*

ANNUAL UPDATE 1

Please review the information above and write in any changes to your child's days and hours normally in care, and the meals normally received while in care. **Initial and date all changes.**

Additional Information

Signature of Parent/Guardian ➢	Date Signed *Mo./Day/Yr.*

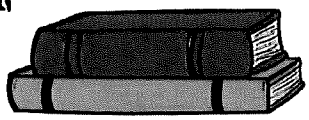
ANNUAL UPDATE 2

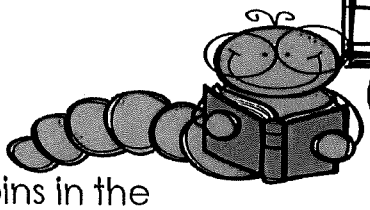
Please review the information above and write in any changes to your child's days and hours normally in care, and the meals normally received while in care. **Initial and date all changes.**

Additional Information

Signature of Parent/Guardian ➢	Date Signed *Mo./Day/Yr.*

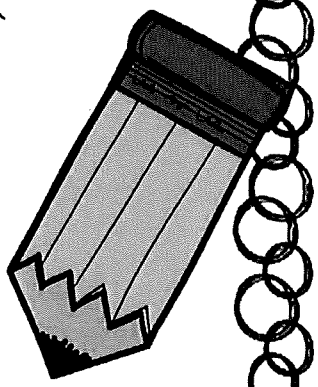
School Supply List





Please drop these items off into the designated bins in the classroom during the open house Friday, September 7th. I appreciate all of the classroom donations and you providing your scholar with materials to be successful this year. Thank you for your commitment as we start the new school year!

- 1 – 1 inch clear front pocket binder
- 1 – paint shirt labeled with scholar's name
- 1 – complete extra set of clothing (including socks) in a labeled Ziploc bag
- 1 – labeled standard sized backpack
- 2 – 4 oz bottles of Elmer's liquid glue
- 3 – thick Elmer's glue sticks
- 6 – thin Elmer's glue sticks
- 1 – 12 pk Crayola colored pencils
- 1 – 24 pk Crayola crayons
- 1 – set watercolor paints
- 1 – 12 pk Crayola classic color markers
- 2 – My First Ticonderoga pencils
- 1 – 4 pk dry erase markers
- 2 – large boxes of tissue
- 2 – packs of colored construction paper
- 2 – reams of standard copy paper
- 1 – plastic folder with pockets and 3 metal prongs in the middle for daily communication
- 1 -- notebook labeled with scholar's name



Things My Teacher Needs To know

My name is:

1. Everyone calls me by this name:

2. My Parents (guardians) Names:

3. Language spoken in my household

4. What makes me happy:

5. Things I dislike:

6. Things that scare me:

7. What helps me to calm down when I'm upset?

8. What makes me unhappy?

9. Any allergies:

10. Potty-trained? Diapers? Need Assistance? Accidents?

11. Forms of communication I use: (example: verbal, gestures, pointing, sign language, pictures, devices, tactile symbols, etc.):

12. Things my teacher needs to know about me: (example: seizures, tube-fed, private nurse, medical conditions, or anything else the teacher should know):

Things My Teacher Needs To know

13. When I'm upset or when people get in my space, I may react this way: (example: cry, hit, bite, pinch, scratch, kick, etc.)

14. When I do this, I need or want this: (example: clap my hands – want more)

15. Will I be taking meds at school?

16. My name (will I respond to my name, can I write my name, can I spell my name, do I recognize my written name, etc.)

17. Can I count to 10? Still in Progress?

18. Can I recite and recognize letters of the alphabet? Still in progress?

19.. Other things I might want to share: