



Child Profile - Please take a moment to complete this profile to help us get to know your child

Child's Name	Child's DOB:
First Parent/Guardian Name	Second Parent/Guardian Name
Does your child have any allergies? Yes No If so, please list what they are and what reactions they experience from them:	
Does your child have any food restrictions and/or religious preferences? Yes No If so, please list them here:	
Please let us know of any birthmarks your child may have.	
What is important to you about your child's care?	
Please list favorites for your child: (games, books, activities)	
Does your child have any siblings? If so, please list the names and ages of all children in your home.	
Does your child have any pets? If so, please tell us what you have and what the name of your pet is.	
Has your child been in preschool before?	
Is there anything else you would like us to know about your child?	
What days will your child be attending?	
Parent/Guardian Signature:	Date:



CDC/SGH# or name: _____

**Arizona Department of Health Services
Bureau of Child Care Licensing
Emergency, Information and Immunization Record Card**

Child's Name:	Date Enrolled:	Updated:
Home Address (#, Street, City, State, Zip Code):		Date Disenrolled:
Home Phone:	Date of Birth:	Sex: <input type="checkbox"/> male <input type="checkbox"/> female

Parent or Guardian Name:	Home Address (#, Street, City, State, Zip Code):
Cell Phone (optional):	Contact Telephone Number:

Parent or Guardian Name:	Home Address (#, Street, City, State, Zip Code):
Cell Phone (optional):	Contact Telephone Number:

**I authorize the following individuals to collect my child from the facility in case of emergency or if I cannot be contacted:
(Pursuant to R9-5-304.B, at least two contact persons are required.)**

Name:	Contact Telephone Number:
Name:	Contact Telephone Number:
Name:	Contact Telephone Number:
Name:	Contact Telephone Number:

If Medical care is necessary, call:

Health Care Provider*	Name:	Contact Telephone Number:
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*A Health Care Provider is a physician, physician assistant or registered nurse practitioner.

I hereby give authority to any hospital or doctor to render immediate aid as might be required at the time for his/her health and safety.

In case of injury or sudden illness, I request that this individual be called first:	
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The following individual(s) may NOT remove my child from the facility:

Name(s):

Custody papers have been provided and are on file at the facility. yes no

Telephone Authorization Code (optional): _____

Immunization Information

(A licensee shall attach an enrolled child's written immunization record or exemption affidavit to the enrolled child's Emergency, Information and Immunization Record card.)

For information regarding current immunization requirements go to:

www.azdhs.gov/phs/immun/index.htm or contact the Arizona Immunization Program Office at (602)364-3630.

One of these items must accompany the EIIR card at all times:

<input type="checkbox"/>	Copy of current official documented immunization record attached
<input type="checkbox"/>	Religious Beliefs exemption form signed by parent/guardian attached
<input type="checkbox"/>	Medical Exemption form signed by physician and parent/guardian attached
<input type="checkbox"/>	Signed Laboratory Proof of Immunity form attached

Notification of immunizations needed sent to Parent(s) or Guardian(s):	mo /day/ yr	mo /day/ yr	mo /day /yr
Updated immunizations received and attached:	mo /day/ yr	mo /day/ yr	mo /day /yr

Medical Information

<p>Is child allergic to food or other substances? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, describe symptoms, name foods or substances to be avoided, and the procedure to follow if reaction occurs:</p>
<p>Is child usually susceptible to infections and if so, what precautions need to be taken? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, list precautions:</p>
<p>Is child subject to convulsions and what should be our procedure if one occurs? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, specify procedure:</p>
<p>Is there any physical condition that we should be aware of and what precautions should be taken (heart trouble, foot problem, hearing impairment, hernia, etc.)? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, list precautions:</p>
<p>Additional comments:</p>
<p>Other special instructions:</p>

This **Emergency Information and Immunization Record Card** is accurate and complete, front and back, and was provided by:

Parent/Guardian PRINTED Name:	SIGNED Name:	DATE:
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PARENTAL ACKNOWLEDGMENT

Please initial the following statements:

INJURY/ACCIDENTS

_____ Valley Child Care prides itself on maintaining a safe and healthy environment; however, I understand that illness and accidents may occur despite the best efforts of all staff employed by Valley Child Care.

REGISTRATION FEE

_____ I understand that there is an annual registration fee per family upon enrollment and every January thereafter.

MEDIA RELEASE

_____ I give permission for Valley Child Care to take pictures of my child/ren to use in their facilities and advertising materials.

PAYMENT

_____ I agree to pay my account in full by Friday night. If I fail to do so, I agree to pay a \$30.00 late payment fee for the past week charges and understand that I will not be authorized to attend until the balance is paid in full.

AGENCY REIMBURSEMENT

_____ If I receive Agency Reimbursement of any kind, I understand that I am solely responsible for ANY payments not covered by the Agency.

If I fail to sign in on both the sign in sheets and the computer for attendance for any day my child is in attendance and reimbursement is denied, I understand that I am solely responsible for the payment of tuition.

_____ **Tuition Express** - Valley Child Care uses Tuition Express for our payment processing service. I understand that I am signing up for automatic payments by Credit/Debit card or ACH before my child's first day of enrollment.

_____ I understand that I am responsible for any fees associated with a declined credit/debit card or insufficient bank account funds.

_____ I understand that there is a convenience fee for each payment made by a Credit, Debit, Flex Savings Card or any type of Cash Card. There is no fee for ACH payments.

_____ I have read the Parent Handbook available [here](#) and agree to the policies in the Handbook as well as on this Parental Agreement

Signature -Parent or Guardian

Date

BEST OF CARE

This confidential form is to help your child care provider support the growth and development of your child while creating a safe, stable and healthy environment for all children. By providing complete information about your child, you will be assisting us in creating a positive experience for your child while in child care.

Instructions: This form is to be completed by a parent/guardian and must be on file at the child care facility on or before a child's first day of attendance. If additional space is needed, attach a separate sheet of paper.

CHILD'S NAME	DATE OF BIRTH
PARENT/GUARDIAN COMPLETING THIS FORM	WHAT IS YOUR PREFERRED METHOD OF COMMUNICATION?
PROVIDER/CENTER NAME	

Has your child attended child care in the past? Yes No
 If yes, what type of setting(s) was your child in? (Family child care, group care, etc.)

What did you like most about your child's previous child care setting?

What did you like least?

Other comments:

What is important to you about your child's care?

Who is important to your child?

Does your child prefer to play alone or with other children? Alone Other children

Does your child have a favorite toy or comfort object? Yes No

If yes, what?

What is your child's current sleep schedule?

Does your child fall asleep easily? Yes No

What is his/her mood upon waking?

What does your child like?

What does your child dislike?

CHILD'S NAME

Special things you say or do to comfort your child are?

How do you know when your child is:

Happy?

Sad?

Mad?

Tired?

Other?

How does your child react when:

Something unexpected happens?

Something happens he/she doesn't like?

He/She is scared?

Other?

Does your child have any health issues? Yes No

If yes, please explain:

Does your child have any other special needs? Yes No

If yes, please explain:

Events at home often influence a child's behavior, for example: changes in the family, such as a new sibling, separation or divorce, or moving to a new home. Knowing about these transitional times will allow us to provide special attention, understanding, and care that your child needs.

Has anything happened recently in your child's life that might have an effect on him/her? Yes No

If yes, please explain:

Is there anything else you would like to share about your child that you feel would help us create a positive environment and relationship for your child?

Parent/Guardian declined to complete

Parent/Guardian Signature

Date

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact 602-542-4248; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request. • Disponible en español en línea o en la oficina local.



APPENDIX A

Video and Audio Recording Acknowledgement

CENTRE/ER: _____

CHILD(REN)'S NAME(S): _____

I have received and read the Busy Bees North America CCTV Policy in full and understand it, including without limitation the Purpose, Location and Access as outlined. I give consent to BBNA to record the activities of my child(ren) in accordance with the CCTV Policy.

Parent / guardian printed name

Parent / guardian signature

Date Signed