Little Angels Daycare and Preschool Menu May 29- Sept. 29

Week	Meal	Monday	Tuesday	Wednesday	Thursday	Friday
May29-June2	Breakfast	Cereal with Milk and Juice	Pancakes, Oranges, Milk	Cereal with Milk and Juice	Muffins,Banana, milk	Cereal with Milk and Juice
june 26-30	Lunch	Ravioli w/ Cheese, corn	hot dogs on buns	Bagel Chicken Sandwich	Pizza Rolls, Lettuce W/ Carrots	Cheesy spanish rice wrap
july24-28		Pineapple, Milk	Man. Oranges, Green Beans	Peas,Pears Milk	Applesauce Milk	Mixed Fruit,Corn, Milk
Aug. 21-25	Toddler Lunch		Hot dogs on Butter Bread, Milk		Mixed Veg.	
sept.18-22	Snack	Animal Crackers, Milk	Chex mix, Juice	Bread Pudding, Milk	Pretzels Rods, Juice	Nachos with salsa,water
	Toddler Snack					Nachos, Juice
June 5-9	Breakfast	Cereal with Milk and Juice	Pancakes, Oranges, Milk	Cereal with Milk and Juice	Waffles, Banana, milk	Cereal with Milk and Juice
july 3-7	Lunch	Fish Sticks, Peas,	Pasta Pizza,	Cowboy Beans and Weiners,	Pizza, Lettuce W/ Carrots,	Cheese & Chicken Quesadillas
july31-Aug. 4		Man. Oranges, Milk	Green Beans, Peaches, Milk	Corn Muffins, Fruit Cocktail, Milk	Applesauce Milk	w/Salsa, Corn, mixed fruit, Milk
Aug. 28- Sept 1	Toddler Lunch				Mixed Veg.	
sept. 25-29	Snack	Blueberry Muffins/Milk	Cheese Puffs, Juice	Graham Cracker, Cool Whip	Popcorn, Puff Corn, Juice	Jello, Animal Crackers
	Toddler Snack			Water		Water
June 12-16	Breakfast	Cereal with Milk and Juice	Pancakes, Oranges, Milk	Cereal with Milk and Juice	*Breakfast Buffet, Banana, milk	Cereal with Milk and Juice
july 10-14	Lunch	Cold sub sandwich	Extra Cheesy Mac and Chesse	Ham & Cheese wraps, Green bean	Pizza Rolls, Lettuce W/ Carrots,	Cheese quesadilla
Aug 7-11		Corn, Fruit Cocktail, Milk	Peas, Peaches, Milk	Pears, Milk	Applesauce Milk	Green Beans, Mixed Furit, Milk
					Mixed Veg.	
Sept. 4-8	Toddler Lunch					
		Choc, Muffins, Milk	Carrots and ranch, Juice	graham cracker, Milk	Pretzels, Juice	Pudding W/ Animal crackers
	Toddler Snack		Cheerios, Juice			Water
June 19-23	Breakfast	Cereal with Milk and Juice	Pancakes, Banana, Milk	Cereal with Milk and Juice	Waffles, Banana, milk	Cereal with Milk and Juice
July 17-21	Lunch	Chicken Nuggets	Corn dog bread	Lunchable , Green Beans	Pizza, Lettuce w/ Carrots	Extra Cheesy Mac and Chesse
Aug. 14-18		Tator tots, Fruit Cocktail, Milk	Corn, Pears, Milk	Yogurt w/ Fruit, Milk	Mixed Vegtables, Peaches, Milk	Peas, mixed fruit, milk
sept. 11-15	Toddler Lunch					
		Goldfish, Juice	Oatmeal cookie, Milk	Graham cracker, Cool Whip	Trail Mix, Juice	Pudding, Vanilla Wafers, Water
	Toddler Snack			Milk		

*Breakfast Buffet is a mix up of assorted pancakes and waffles. Children are allowed to choose two items to go with their fruit.

Notes: In addition to above menu listing, condiments such as catsup, ranch dressing are to be provided when appropriate .Menu is subject to changes due to availability and speical event. Please check the menu in the lobby for any changes.

Ohio Department of Job and Family Services

REQUEST FOR ADMINISTRATION OF MEDICATION FOR CHILD CARE

Box 1	The following section must always be completed by the parent/guardian.

Check all that apply and complete all of the information.

☐ Prescription Medication ☐ Nonprescription Medication ☐ Food Supplement

☐ Topical Product or Lotion ☐ Refrigeration Required ☐ Modified Diet

Name of Child	Date of Birth	Weight

Name of Medication	Exact Dosage

To be administered at the following times	For the following period of time

☐ I understand that my child must receive one dose of medication before arriving at the program (unless the medication is used for emergencies).

Signature of Parent/Guardian	Date

Box 2	The following section must be completed by a licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant.

1. The medication contains codeine or aspirin.
2. A physician's instruction is needed for a nonprescription medication (e.g. child does not meet minimum age or weight requirements as listed on the label instructions).
3. It is a sample medication without a prescription label.
4. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period.
5. The topical product or lotion and the physician's instructions exceed the manufacturer's instructions or use.

Name of child	Name of medication, vitamin, diet, supplement
Dosage	Possible side effects to watch for are

Expiration date

(May not exceed twelve months from the date of this request for medications of food supplements).

Instructions

This child is under my care and should receive the above medication as written.

Signature of physician, dentist, advanced practice registered nurse or certified physician's assistant

Date of signature	Phone number

Name of child	Name of medication, vitamin, diet, supplement

This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.

Little Angels
Child Handbook Agreement

I, ___________________________________, parent/guardian of
_________________________________, (Parent/Guardian Name)
(Child's Name) have read and understand the above the Little Angels Child Handbook, Biting Policy, transition policy and Discipline policy in place at Little Angels and agree to follow these guidelines.

_____________________________________ ____________

Parent/Guardian Signature Date

_____________________________________ ____________

Director Signature Date

Ohio Department of Job and Family Services

CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name *(print or type)*	Date of Birth

✓ This above named child has been examined, the immunization status recorded, and the child is in suitable condition for participation in group care.

✓ This above named child has been immunized in accordance with the requirements of section 5104.014 of the Ohio Revised Code (please note any exceptions below).

Signature of Examining Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner	Date of Examination
Name of Physician/Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner	Telephone Number
Street Address	
City, State and Zip Code	

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD WITH DATES OF DOSES OF ALL IMMUNIZATIONS

Exceptions to Immunization requirements pursuant to 5104.014 ORC (please include names of requirement diseases against which the child has not been immunized and whether it is because the immunization is medically contraindicated, not medically appropriate for the child's age, or declined by the parent).

☐ I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised Code. Please note disease above and sign.

Signature of Parent	Date of Signature

Optional
Recommended Assessments/Screenings

Vision	☐ Yes ☐ No	Lead	☐ Yes ☐ No
Hearing	☐ Yes ☐ No	Hemoglobin	☐ Yes ☐ No
Dental	☐ Yes ☐ No	Other	

Measurements		**Notes**
Height		
Weight		
BMI		

Ohio Department of Job and Family Services

CHILD MEDICAL/PHYSICAL CARE PLAN FOR CHILD CARE

Child's Name	Date of Birth

Special Health Conditions

Symptoms to watch for and emergency action to be taken if the following symptoms occur

Activities/foods/environmental conditions to avoid. if applicable

Medical procedures to be followed and expected benefit of treatment. if applicable

Are any medications required? ☐ Yes ☐ No *(If yes. complete JFS 01217 "Request for Administration of Medication")*
If yes. what medications?

In an emergency does this child require additional assistance (more than other children of the same age or in the same group) to evacuate? ☐ Yes ☐ No

In the event that the child care program must be evacuated, are there medications or supplies that must be taken with this child? ☐ Yes ☐ No

Training Instructions *(Trainer must be a parent or certified professional)*

Signature of Trainer	Date

Signature of trained providers, substitutes or child care staff members who have been made aware of the condition.
(There must always be a trained caregiver present when the child is present)

Signature	Date	I have been ☐ Informed	I have been ☐ Trained
Signature	Date	I have been ☐ Informed	I have been ☐ Trained
Signature	Date	I have been ☐ Informed	I have been ☐ Trained
Signature	Date	I have been ☐ Informed	I have been ☐ Trained

(Only trained providers, substitutes or child care staff members shall be permitted to perform medical procedures listed above.)

Additional services (educational/therapeutic) child is receiving

Who provides the above services?

Name	Phone Number	May we contact? ☐ Yes ☐ No
Name	Phone Number	May we contact? ☐ Yes ☐ No

I give my permission for the staff listed above to perform the procedures in my child's Medical/Physical Care Plan.

Parent Signature	Date
Administrator/Provider Signature	Date

Note: A separate plan must be written for each condition that requires different actions to be taken

Little Angels Daycare

Walking Permission Form

I, ____________________________ (print parent/guardian name),
give my child, ____________________ (child's name)
permission to go on neighborhood walks with the Little
Angels Daycare.

Parent/Guardian Signature: ____________________ Date: ___________

Ohio Department of Job and Family Services

SLEEP POSITION WAIVER STATEMENT FOR CHILD CARE

Safe Sleep Practices

Sudden Infant Death Syndrome (SIDS) is the sudden and unexplained death of an infant under one year of age. Doctors don't know what causes SIDS, but they have found some things that can make babies safer. The American Academy of Pediatrics and the National Institute of Child Health and Human Development state that one of the most important things that can help reduce the risk of SIDS is to put healthy babies on their backs to sleep. State regulations require child care centers, family child care, and in-home aides to place all infants to sleep on their back. A few babies have health or medical conditions that might require them to sleep in an alternative position. At the advice of the infant's physician, the child care program may be authorized to use an alternative sleep position for the infant due to health or medical conditions. If an infant is to be placed in the crib in any other positions than on their back, this form must be completed by the child's physician and signed by the parent.

To Be Completed by the Infant's Parent/Guardian

Name of Infant		Date of Birth
Name of Primary Care Physician		
Name of Practice		
Address		
Phone	Fax *(optional)*	Email *(optional)*
Signature of Caretaker/Parent *(authorizing this instruction)*		Date

To Be Completed by the Infant's Primary Physician

The above named infant has the following health or medical condition that necessitates an alternative sleep position	
Describe the appropriate sleep position for the above named infant	
Additional instructions	
Signature of Physician	Date
This above instruction is effective from *(date)* to *(date)*	

Children's ____

____

Parents Name____

One call number (___)______________ (will receive all voice messages)

1-2 emails ______________________ ______________________

Text message (___)________________ (___)________________

If you don't want any of these notifications, please fill out names and just mark N/A on the line.

Little Angels
DAYCARE
PRESCHOOL

80 E. Parkview Drive
Brookville, Ohio 45309
937-833-3365

February 14, 2017

Dear Parents

Most of you know that I have taken over as the new director and have been updating and processing many policies to ensure we are following all the state guidelines. Part of this means we will be updating our lockdown and emergency procedures. This will require receiving information from each family. I will be setting up a One Call system which will require one phone number per family to receive any calls- 1-2 emails, and 1-2 cell numbers to receive text messages. We will start using these methods to send out information to parents to ensure all parents are aware of all information. This should eliminate parents missing important information. We will also have some information available on Facebook and on our website.

Please be ready to talk to your child about lockdown procedures as these can be viewed as a scary practice, but we are hoping this will never occur but the children's safety is our priority. The more we practice the less scary they should become.

Sincerely,

Kacie Whaley- Director

Photo Release Form

Please be advised that your child may be photographed or video recorded at various daycare/ Preschool activities. If you would like your child's photo to appear on our Facebook page or website or Shutterfly, please sign and return this form.

Please sign and return this form.

________ **YES**, I give permission for my child's photography and or video to be posted on Little Angels sites.

________ **NO**, my child's photography and/or video may not be posted on Little Angels sites.

______________________________ ______________

(Signature) (Date)

____

(Children's First and Last names)

Child's Name

List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff **or medical personnel** in an emergency situation.

List any additional information about your child that would be useful for staff to know, such as fears, eating or sleeping habits, or special routines. This information should not be medical or health related, as that information should be included on the previous page.

Diapering Statement

Is your child toilet trained? ☐ Yes (If yes, skip to Emergency Transportation Authorization section) ☐ No (If no, fill out the following)

The program's policy is to check diapers every _____ hours. Please indicate if you want your child's diaper checked according to the program's policy or another:

☐ I agree with the program's schedule ☐ I do not agree, please check my child's diaper every _____ hours.

Emergency Transportation Authorization

Give *Permission* to Transport		**OR**	***Do Not Give Permission* to Transport**	
Program or Home Name		Do not sign both	Program or Home Name	
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.			**does not have permission** to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:	
Parent's Signature	Date		Parent's Signature	Date

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. ☐Yes ☐No *(check one)*

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.

Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note: This is a prescribed form which must be used by child care providers to meet the requirements to rules 5101:2-12-15 and 5101:2-13-15. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

Child's Name

Allergies, Special Health or Medical Conditions, and Food Supplements

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Medical/Physical Care Plan" or equivalent form and/or the JFS 01217 "Request for Administration of Medication" must be completed and be kept on file at the center or family child care home.

Does your child have any food, medication or environmental allergies? (*check all that apply*)
☐ No
☐ Yes - check all that apply ☐ Food ☐ Medication ☐ Environmental Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms, take action if a reaction occurs, or give emergency medication to your child? (*check one*)
☐ No
☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Does your child have a special health or medical condition? (*check one*)
☐ No
☐ Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (*check one*)
☐ No
☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Is your child currently using any medication, food supplement or medical food (such as electrolyte solution)? (*check one*)
☐ No
☐ Yes - please explain

If yes, does this medication, food supplement, or medical food need to be administered at the child care center/type A home?
☐ No
☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication, food supplement or medical food.
☐ N/A - program does not administer any medications.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)
☐ No
☐ Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?
☐ No
☐ Yes - written instructions from the child's health care provider must be on the JFS 01217 "Request for Administration of Medication."
☐ N/A - child does not attend a full time program.

Ohio Department of Job and Family Services

CHILD ENROLLMENT AND HEALTH INFORMATION FOR CHILD CARE

This form shall be completed prior to the child's first day of attendance and updated annually and as needed.

Child's Name | Date of Birth | First Day at Program/Home

Home Address | City

State | Zip Code | Home Telephone Number

Parent/Guardian Name | Relationship to Child

Home Address | Home Telephone Number

City | State | Zip

Email Address (if applicable) | Cell Phone

Parent's Work/School Telephone Number | Parent's Work/School Name

Parent's Work/School Address | City

Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Parent/Guardian Name | Relationship to Child

Home Address | Home Telephone Number

City | State | Zip

Email Address (if applicable) | Cell Phone

Parent's Work/School Telephone Number | Parent's Work/School Name

Parent's Work/School Address | City

Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Emergency Contacts: Parents <u>**cannot be listed**</u> as emergency contacts. List the name <u>of at least one person</u> who can be contacted in the event of an emergency or illness **if you cannot be reached.** Any person listed should be able to assist in contacting you. At least one person listed must be within one hour of the center/home, able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.

Name		Name	
City	State	City	State
Telephone Number	Relationship to Child	Telephone Number	Relationship to Child
Other numbers where emergency contact can be reached *(if applicable)*		Other numbers where emergency contact can be reached *(if applicable)*	

Name of Physician or Clinic/Hospital

Street Address

City | State | Telephone Number

Does your child have trouble sleeping (Night terrors, trouble going to sleep, etc.)? Please explain.
What might you and/or your child be anxious about as he/she starts in this program?
What are you and/or your child excited about as he/she starts in this program?
What are your expectations of this program?
What other information would be helpful for the staff caring for your child to know?

Parent/Guardian's Signature	Date

Please check all of the words that best describe your child's personality and behavior

☐ active ☐ adventurous ☐ affectionate ☐ anxious ☐ bossy ☐ bright ☐ busy ☐ calm ☐ cautious ☐ cheerful
☐ content ☐ creative ☐ curious ☐ easily-angered ☐ emotional ☐ energetic ☐ excitable ☐ friendly ☐ gives-in-easily
☐ happy ☐ hesitant ☐ insecure ☐ jealous ☐ likes structure/routines ☐ loud ☐ loving ☐ mellow ☐ outgoing
☐ prefers adult attention ☐ quiet ☐ sensitive ☐ serious ☐ shares-well ☐ social ☐ spontaneous ☐ stubborn ☐ tentative
☐ other:

Are there additional personality and behavior characteristics that would be useful to know about your child?

Are there things that frighten your child? If so, how does he/she react and what do you do to comfort him/her?

What routines/actions or items do you use to comfort your child?

What causes your child to feel angry or frustrated?

What methods do you use to respond to your child's negative behavior?

Does your child use any special comfort or support items that help him/her go to sleep? If so, what?

What is your child's mood upon waking? (happy, grouchy, clingy, slow to awaken)?

My child sits in a ☐ high chair, ☐ booster, ☐ child size chair or ☐ adult size chair. *(Check the one that applies.)*

Is your child toilet trained? If not, have you started the toilet training process? Please explain the process used.

Does your child need assistance when using the toilet? If so, how?

What words, gestures or signs does your child use if he/she needs to use the bathroom?

What time does your child normally go to bed at night and wake up in the morning?

What time(s), and for how long, does your child usually nap?

Ohio Department of Job and Family Services

FAMILY INFORMATION
FOR STEP UP TO QUALITY PROGRAMS (SUTQ)

Child's Name *(Last)*	*(First)*	Nickname *(If any)*

By providing complete information about your child, you will be assisting staff in creating a positive experience for him/her while in care. List any information about your child's habits, abilities or personality that you feel will be helpful to the staff while caring for your child.

Who is in the child's immediate family?

Who lives at home with your child?

What is the primary language spoken in your child's home?

Are there any special family arrangements, such as shared parenting, living in two homes, or custody specifications, etc.? Additional Details?

Are there any changes or transitions that your child has recently experienced or is experiencing? (moved from crib to bed, divorce, new home, death of family member, friend or pet) Additional Details?

Are there any cultural or religious practices of your family we should be aware of? (Dietary restrictions, clothing, head coverings, etc.)

Do you have any pets at home? If so, what are they and what are their names?

Has your child had a previous care arrangement? ☐ Yes or ☐ No Additional Details? (Center based, in home, with family, with parents, etc.)

My child drinks ☐ milk, ☐ formula, ☐ juice or ☐ water. *(Check all that apply)*
How much and how often?

Does your child have any favorite foods?

Does your child dislike any foods?

Are there any foods your child should not be fed? (Licensing requires documentation be completed for children with food allergies and/or dietary restrictions)

Little Angels Daycare and Preschool

Schedule and Tuition Verification Form

Child's Name: ______________________________

Classroom: ______________________________

Schedules Start Date: ______________________________

Dear Parents,

Please fill out your child's attendance schedule below. All children must attend three days a week to hold their spots. You can always change your schedule as needed based on the availability in your Childs classroom. You will be required to pay the tuition amount listed at the bottom until you request a schedule change.

	Arrival Time	Departure time
Monday	____________	____________
Tuesday	____________	____________
Wednesday	____________	____________
Thursday	____________	____________
Friday	____________	____________

According to the above schedule, I agree to pay $ ____________ a week for my Childs's tuition at Little Angels Daycare and Preschool. I understand the weekly tuition is due regardless of my child's attendance on the following Wednesday after each billing cycle that is sent out on Fridays. If you exceed your scheduled time you will automatically move up to the next hourly rate. As part of your agreement if no payment has been received within a three week period your child will no longer qualify to attend Little Angels Daycare and Preschool. Upon receiving payment you may be required to pay a registration fee to renroll them.

Parents/Guardian Signature: ______________________________ Date: ____________

Office Use:

Signature: ____________ Approval Date: ____________

(Rev. 4/2015)

Little Angels Daycare and Preschool

Authorized Pick-Up and Emergency Contacts

Child's Name: ______________________ **Updated:** ______________________

Please list at least four individuals who are permitted to pick up your child in case of an emergency and in the event that the parent/guardian can not be contacted. Any person listed should be able to assist in contacting you. At least one person listed must be within one hour of the center, and able to take responsibility for the child in case the parent/guardian can not be contacted. All authorized emergency contacts must be 18 years of age. **All information needs to be fully filled in. *Identification(Drivers License will need to be brought when picking a child up.**

Name: ______________________
Address: ______________________
City: ______________ State: ______
Relationship to Child: ______________________
Cell Number: ______________________
Home Number: ______________________
Work Number: ______________________

Name: ______________________
Address: ______________________
City: ______________ State: ______
Relationship to Child: ______________________
Cell Number: ______________________
Home Number: ______________________
Work Number: ______________________

Name: ______________________
Address: ______________________
City: ______________ State: ______
Relationship to Child: ______________________
Cell Number: ______________________
Home Number: ______________________
Work Number: ______________________

Name: ______________________
Address: ______________________
City: ______________ State: ______
Relationship to Child: ______________________
Cell Number: ______________________
Home Number: ______________________
Work Number: ______________________

Little Angels Daycare & Preschool
80 E. Parkview, Brookville, Ohio 45309
(937) 833-3365

Application for Enrollment

Date of Admission: ____________ Current Age: ____________

Parents: Please be accurate while completing this enrollment packet. All areas must be fully completed. If an area does not apply to you, please write n/a

Child Information:

Name: ____________ Date of Birth: ____________

Home Address: ____________ Phone Number: ____________

City: ____________ State: ____________ Zip Code: ____________

Parent/Guardian Information:

Mother/Guardian Name: ____________

Home Address: ____________

Home Phone: ____________ Cell Phone: ____________

Employer: ____________ Phone Number: ____________

Employer's Address: ____________

Father/Guardian Name: ____________

Home Address: ____________

Home Phone: ____________ Cell Phone: ____________

Employer: ____________ Phone Number: ____________

Employer's Address: ____________

Little Angels Daycare & Preschool
80 E. Parkview
P.O.Box 1
Brookville, OH 45309

Dear Parents:

Welcome to Little Angels Daycare & Preschool. We are happy to have you as a part of our center. We look forward to new and exciting times with your children. The following is a list of things we need to be sure you know.

1. Please fill out all forms completely. We will need the Child's Medical Statement filled out by your child's physician before your child can start.
2. We will need the $50 Registration fee before or on your child's first day.
3. You must accompany your children into the building. You will be required to sign your child in and out each day in their assigned classroom.
4. Invoices come out at the end of each week. Payments need to be paid by the Wednesday of the next week. Payments can be put in the drop slot on the front office door. IF your check is returned, there will be a returned check fee.
5. If you are late picking up your child, you will be charged $1.00 for each minute you are late.
6. Each child will need to bring a pillow, blanket, or favorite animal to lay with at rest time. These can be left at the daycare all week and then taken home on Friday's to be cleaned. We do not expect the children to sleep, but we do require rest and quiet time.
7. You will also need to provide diapers, diaper wipes, and extra clothing.
8. You will also need to provide formula, baby food, or any other food if your child is not on regular food.

If you have any questions, please do not hesitate to ask.

Thank you so much.
Little Angels Daycare