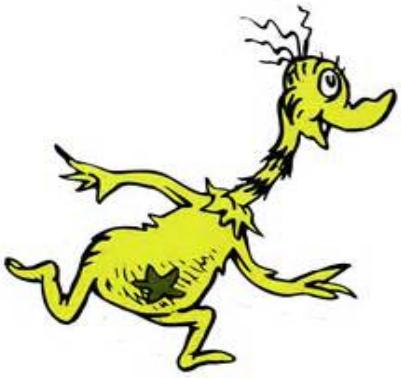
Oh, The Places You Will Go Daycare

204 5th Street
Rawlins, WY 82301

Oh, The Places You Will Go Daycare is a licensed full-time daycare facility. It is our goal to provide quality childcare for all families in the community in a warm, nurturing, loving and educational environment.

Nutritious meals which meet the guidelines of the federal government food program will be served every day including breakfast, morning snack, lunch and afternoon snack.



Daily activities include:
Walks or Outings
Story Time
Art and Crafts
Music and Dance
Naps and Quiet Time
Free Time

APPLY FOR ENROLLMENT TODAY ☺

Hours of Operation:
Mon-Fri
5:30 am – 6:30 pm

Contact:
Phone: (307) 212-2215

This facility is open year-round.

Tuition Fees: Newborn/Infants
Overtime: (50-65 hours/week) $750/Month
Full Time: (40-49 hours/week) $700/Month
Mid Time: (30-39 hours/week) $600/Month
Part Time: (20-29 hours/week) $500/Month

Tuition Fees: Ages: 1-6
Overtime: (50-65 hours/week) $700/Month
Full Time: (40-49 hours/week) $600/Month
Mid Time: (30-39 hours/week) $500/Month
Part Time: (20-29 hours/week) $400/Month

Hourly: Ages: 1-6 years (1-19 hours/week)
$5/hour

Discount
Sibling Discount: $100 off second child.

Drop-ins are welcome!
Ask us about payment options.
Let us know if you have any questions on how we bill.

Oh, The Places You Will Go Daycare
204 5th Street
Rawlins, WY 82301

CHILDCARE APPLICATION FOR ENROLLMENT

Child Information

Age:_____ Date of Birth:_____ Sex:_____

Full name:_____

Requested start date:_____

Is your child potty trained? Yes No

Are you interested in full, mid or part time?_____

If mid or part what days/hours?_____

Has your child been in daycare before? Yes No

Family information

Mother: _____

Email:_____

Phone:_____

Father: _____

Email:_____

Phone:_____

Medical information

Please list allergies, special medical, dietary needs or other areas of concern:

Parent signature: _____

Date: _____

Parent Payment Preferences

Mother

Name:_____

Email Address: _____

Phone: _____

Father

Name:_____

Email Address: _____

Phone: _____

(**Email will be used for parents Brightwheel account**)

Name of Child/Children enrolled: _____

_____

_____

Payment Preference: (Please circle your answer below)

Cash

Check

Bank Transfer: (Please provide a voided check)

Credit/Debit:

Online through emailed Invoice: (Instructions will be sent to your email provided with the invoice so that you can pay online.)

Split payment: due on the 5th and 15th of the month. (Please circle your answer below)

YES NO

Automatic Payments. (Please circle your answer below)

YES NO

If you circled yes for ***Automatic Payments*** please sign here: _____

CHILD RECORD FORM

Today's Date: _____ **Child's Date of Birth:** _____

If Pregnant, Due Date: _____ **Date of Enrollment:** _____

Child's Name: _____ **Nickname:** _____

Address: _____ **Sex:** _____

City/Zip _____ **Phone:** _____

Mother's Name: _____

Home Address (if different from above): _____

Employer: _____ **Occupation:** _____

Work Address: _____

Work Phone: _____ **Pager or Cell Phone:** _____

Father's Name: _____

Home Address (if different from above): _____

Employer: _____ **Occupation:** _____

Work Address: _____

Work Phone: _____ **Pager or Cell Phone:** _____

Names of Siblings: _____ **Age** _____

_____ **Age** _____

_____ **Age** _____

Medical Information

Physician: _____ **Phone:** _____

Dentist: _____ **Phone:** _____

Insurance Information:

Insurance Company: _____

Name of Subscriber: _____ **ID Number** _____

PARENTS ARE RESPONSIBLE FOR ALL EMERGENCY MEDICAL TREATMENTS.

In case of emergency, contact: _____

Relationship to child: _____ **Phone:** _____

Other than the above parent/guardians, only the following person(s) may remove your child from care without previous notice. PHOTO ID WILL BE REQUIRED.

Name	Relationship	Phone

MEDICAL INFORMATION

List any frequent illnesses and/or hospitalizations: (ear infections, strep throat, seizures, etc.)

List any know allergies: _____

What communicable diseases has your child had? (chicken pox, measles, mumps, etc.)

Is your child currently taking medications? ☐ **Yes** ☐ **No**

If yes, what? _____ **Why?** _____

Are there any special medical concerns we should know about? _____

Does your child receive therapeutic services in a developmental center or school? _____

If yes, please check which services:

☐ **Occupational therapy** ☐ **Physical therapy** ☐ **Speech Therapy**

☐ **Behavior therapy** ☐ **Psychological/Counseling services**

Mobility: (check any that apply)

☐ **Walks** ☐ **Uses wheelchair** ☐ **Wears adaptive shoes**

☐ **Uses cane** ☐ **Uses walker** ☐ **Does not move self**

☐ **Crawls**

Would your child be able to evacuate the building without assistance? ☐ **Yes** ☐ **No**

Communication: (check any that apply)

☐ **Wears glasses** ☐ **Wears hearing aides** ☐ **Lip reads**

☐ **Uses light board or other adaptive device** ☐ **Uses sign language or hand signals**

Eating Habits:

If your child is an infant, check which nourishment: ☐ **Breast** ☐ **Formula** ☐ **Combination**

Any history of colic? ☐ **Yes** ☐ **No** **Time of Day?** _____

Child's favorite foods: _____ **Food dislikes?** _____

How has your child been fed? ☐ **Held in lap** ☐ **Highchair** ☐ **At table** ☐ **Other**

Does your child eat unassisted using: ☐ **Fingers** ☐ **Fork** ☐ **Spoon** ☐ **Knife**

Does your child drink from: ☐ **Bottle** ☐ **Sipper Cup** ☐ **Regular Cup**

Does your child require the use of a dropper, weighted cup or other adaptive equipment to self-feed? ☐ **Yes** ☐ **No**

Eating habits you are concerned with? _____

STATE OF WYOMING

OFFICIAL RECORD OF IMMUNIZATION

DAY CARE/PRESCHOOL/HEAD START/PUBLIC AND PRIVATE SCHOOL K-12

Effective June 1, 1999

This record is part of the child's or student's permanent record (cumulative folder) and shall transfer with that record. Health Department personnel shall have access to this record as deemed necessary.

Name of Child/Student

_____ DOB _____

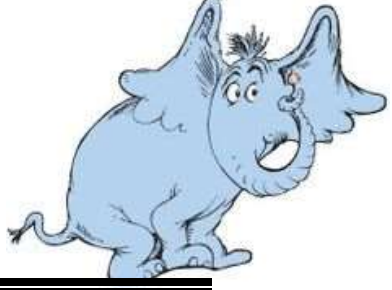
Last First MI Month/Day/Year

Parent or Guardian _____ Phone _____

Address _____ City/State _____ Zip _____

Please provide a copy of child immunization record (with state seal) within 30 days of child's start date

Oh, The Places You Will Go!
204 5th Street
Rawlins, WY 82301
Authorization of Medical Treatment



AUTHORIZED ADULTS

In the event of an emergency, please indicate your name and phone number where you and an authorized person can be reached:

Father's name: _____ Phone: _____

Mother's name: _____ Phone: _____

Other authorized person: _____ Phone: _____

Address: _____

I, _____ hereby give permission to _____ To obtain medical or surgical care from a health care facility, physicians or dentists for my child, whose full name is _____ and date of birth is _____ should the need arise. It is understood that a conscientious effort will be made to locate me before action will be taken. If this is not possible, treatment as deemed necessary by the physicians/dentists may be taken. I further consent to transportation of the above-named child to the nearest or most appropriate medical facility.

The medical insurance company that covers the above-named child is:

Company Name: _____
Company Address: _____
Name of Policy Holder: _____

I authorize the hospital and attending physicians to submit claims to the above-named company and hereby assign benefits directly to this company. I understand that I am financially responsible to providers of service for charges not covered by any insurance payments.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Witness Date

OVER THE COUNTER (OTC) MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY PARENT

Child's Name_____Date of Birth_____/____/___
Program Name_____Today's Date_____/____/___

****

I give permission for the administration of following non-ingestible over the counter medications (mark all that apply):

Diaper Rash Cream/Ointments

Insect Repellent

Sunscreen

Cortisone/Anti-Itch Creams/Ointments

Medicated Lip Treatments

OTC Antibiotic Creams/Ointments

Teething Tablets/Ointments

Burn Creams/Sprays

Other Non-Ingestible OTC's: (Please Specify)_____

_____
_____
_____

To administer a non-ingestible over the counter (OTC) medication:

- The OTC medication must be brought to the day care facility from the parent;
- The OTC medication must be in its original container, with a legible label, and expiration date of medication;
- The child's name must be on the original container

Special handling/storage Instructions_____Refrigeration Y/N

Parent/Guardian Signature (required)_____

* **This document must be updated on an annual basis.**

Unused Medication: Returned to Parent Y/N or Discarded Appropriately (circle one)

By: _____ Date _____/_____/_____

Consent for Child Care Program Activities

Name of Facility: _____ Address of Facility: _____ Name of Child: _____ **Consent is given for the items initialed below:**

WALKING TRIPS

Walking trips to the following locations:

_____ _____

MOTOR VEHICLE TRANSPORTATION

_____ Trips by the program in _____ to the following locations:
(vehicle)

_____

_____

_____ Daily transportation by the program in: _____
(vehicle)

From: _____ to _____
(location) (location)

Children will be restrained during vehicular transport by use of: _____
Special needs of the child during transport: _____

SWIMMING

Swimming and/or wading at:

_____ _____
(location)

OTHER ACTIVITIES (e.g. trips to neighborhood playgrounds, special trips)

_____ _____
(specify activity)

Signature of Parent/Guardian: _____ Date: _____

SUPERVISION NEEDS CHECKLIST

The following information is requested to provide the best care for your child. Your responses assist us in getting to know your child, as well as allowing us to be consistent with daily routines as much as possible. All information is confidential.

Other languages spoken at home:

Have there been any changes in your family structure? (ex. Separation, divorce, death of someone close to your child, a move, marriage?

Is there a family history of learning/behavioral difficulties? _____

_____

Please check the words that best describe your child:

☐ calm	☐ shy	☐ excitable	☐ happy	☐ sensitive
☐ cheerful	☐ loud	☐ quiet	☐ easily angered	☐ stubborn
☐ temper tantrums	☐ active	☐ aggressive	☐ on task	☐ destructive
☐ gives in easily	☐ curious	☐ hyperactive	☐ jealous	☐ bites
☐ shares well	☐ loving	☐ unfocused	☐ bright	☐ slow learner
☐ busy	☐ contented	☐ refuses eye contact		

How does your child get along with other children? _____

How does your child express feelings? _____

What behavior do you find most difficult to handle? _____

What method of discipline works best with your child? _____

Who does most of the disciplining? _____

Are there "family" rules I should be aware of? _____

What are your child's favorite activities? _____

Least favorite? _____

Does your child require assistance with: (check any that apply)

☐ **Buttons** ☐ **Zippers** ☐ **Laces** ☐ **Snaps** ☐ **Velcro**

☐ **Getting pants, shoes, jackets on or off.**

Does your child: (Check any that apply) ☐ **Use a pacifier** ☐ **Suck Thumb** ☐ **Fingers**

Does your child have a "fussy" time? When? _____

How do you handle those fussy times? _____

What frightens your child? _____

Has your child had experience with: ☐ **Other children** ☐ **Siblings** ☐ **Adults**

Has your child been in child care before? ☐ **Yes** ☐ **No**

Restroom Habits

Are bowl movements regular? ☐ Yes ☐ No How many per day? _____

Times: _____

Has toilet training been attempted? ☐ Yes ☐ No

Please check what is used at home:

☐ Diapers ☐ Pull-ups ☐ Potty Chair ☐ Special toilet seat ☐ Regular toilet seat

Does your child have frequent diaper rashes? ☐ Yes ☐ No

Medication used to treat diaper rash _____

Can your child be relied upon to indicate the need to use the restroom? ☐ Yes ☐ No

How does your child communicate this? _____

My child does not indicate the need to use the restroom and should be taken to the toilet every _____ and should not be left unattended for _____minutes.

How often does your child have accidents? _____

Any special comments or concerns? _____

Sleeping Habits

At what time does your child go to bed and night? _____

What time does he/she awaken in the morning? _____

Does he/she wake frequently in the night? ☐ Yes ☐ No Have nightmares? ☐ Yes ☐ No

Does your child have his/her own bed? ☐ Yes ☐ No Require a nightlight? ☐ Yes ☐ No

He/she sleeps in own bed: Whole night ☐ Part night

Does he/she: Walk Talk Cry during the night?

Does he/she take a nap? ☐ Yes ☐ No From _____ to _____

How does your child fall asleep?

☐ Rocking ☐ Holding ☐ On their own ☐ Story ☐ Music

Other: _____

Any other comments or concerns? _____

In what particular way can we help your child? _____

Photo Release Form

As the parent of a child/children at Oh, The Places You Will Go Daycare, I agree to the following: • I understand that my child(ren) whose name(s) are listed below may be photographed at Oh, The Places You Will Go Daycare during normal daycare hours, field trips, or activities. • I understand that these photographs may be used in school newsletters or mounted on the Oh, The Places You Will Go Daycare's website and/or Facebook page. • I give permission for my child(ren)'s photographs to be mounted on Oh, The Places You Will Go Daycare's website, Facebook page, or newsletters. (When names are added, only first names will be used.)

The following are the names of my children attending Oh, The Places You Will Go Daycare:

_____

( ) Yes, I confirm that I have read and understood the above, and agree to have my child (ren)'s photos mounted on the Oh, The Places You Will Go Daycare website, Facebook page, or newsletters.

( ) No, I do not wish to have my child (ren)'s photographs published

Name (please print) _____

Signature: _____

Date: _____