A child cannot begin the ECDC program unless all of the required forms have been completed and are on file in the ECDC office. Please mail or drop off your completed enrollment forms to:

ECDC
University of Notre Dame or Saint Mary’s College
10 Child Care Center Havican Hall
Notre Dame, IN 46556 Notre Dame, IN 46556

1) The following is required for ALL children enrolled at ECDC-ND and is DUE JUNE 1ST. If your child is enrolled in the SU Program, you do not need to resubmit:

_____ Income Documentation – (ECDC-ND only) – Attach a signed copy of the first two pages of your most recent Federal Income Tax Return, Form 1040, to the ECDC Income Documentation Form.

2) The following are required annually for ALL children enrolled in the SY Program and are DUE AUGUST 1ST:

_____ Tuition Payment Options & Parent Agreement Form – Please complete and submit the 2nd page of this form indicating your ECDC tuition payment plan and agreement. Please keep the 1st page as a reference.

_____ Emergency Information & Medical Authorization Form

_____ General Information Form

_____ Emergency Health Information and Medical Plan Form – A physician’s signature is required in section 3 if your child has a medical condition or allergy requiring medications, restrictions, monitoring and/or food substitutions.

3) The following is required for SY Kindergarten children only and is DUE AUGUST 1ST:

_____ Preschool/Kindergarten/Child Care Center Health Record (Physical) Form – Must be completed by a physician; may be completed based on an appointment within the last 12 months; physical and immunizations must be up-to-date and on file within 30 days of enrollment.

4) Please complete the following if applicable:

- **Under-Immunized Agreement** – Please complete if your child is under-immunized due to a medical or religious exemption. Obtain form from ECDC office.

- **Menu Approval & Food Transport Form** – Please contact the ECDC office to schedule an appointment to review menus, discuss any substitutions and sign necessary paperwork if your child has a food allergy.
The income based tuition fee schedule at the Early Childhood Development Center at Notre Dame (ECDC-ND) is based upon current combined family gross income. To be considered for the income based tuition fee schedule program, a copy of your most recent signed Federal Income Tax Return and this form must be completed and submitted to ECDC-ND by May 1 for the summer program and June 1 for the school year program.

If your most recent federal tax return does not reflect your current combined family income (larger or smaller), please provide an email or letter indicating the differences and 6 weeks of payroll summaries. If your family didn’t submit a federal tax return due to being a visiting professional, please provide your appointment letter that includes your salary.

The income based tuition fee schedule is available to ND and SMC staff, students, administration and faculty. It is not available to ND and SMC Alumni(e) and/or Holy Cross Order employees. Those who elect not to provide income information/most recent tax return will be assessed the full tuition rate.

If your child is enrolled for both the summer and school year programs, only one submission of your Federal Income Tax Return with this form is required on or before May 1. Income based tuition eligibility is granted from the first day of the child’s enrollment in the summer program or the school year program, whichever occurs first, through the end of the school year. Verification of combined family gross income is required on an annual basis. If you have any questions, please contact Terri Kosik, Executive Director, at tkosik@saintmarys.edu or 631-3344. Please be assured that all income information will remain strictly confidential.

Early Childhood Development Center - University of Notre Dame

( ) I (we) am not eligible for the income based tuition fee schedule.

( ) I (we) am eligible but do not wish to apply for the income based tuition fee schedule.

( ) I (we) wish to apply for the income based tuition fee schedule for the Summer and/or the School Year Program(s) at ECDC-ND. (This does not apply to ECDC-SMC enrollment.) I (we) have attached a copy of my (our) most recent signed Federal Income Tax Return (first two pages) for review in determining program eligibility. (Please note – this is required for participation in the income based tuition schedule.)

( ) I (we) wish to apply for the income based tuition fee schedule for the Summer and/or the School Year Program(s) at ECDC-ND. I am submitting a letter of appointment because I do not file a U.S. Federal Tax Return.

Child’s (Children’s) Name(s): ____________________________________________

Parent Signature: ____________________________________________

Date: ____________________________________________

Please submit this form and the first two signed pages of your Federal Tax Return by May 1 for summer or June 1 for school year.

Terri Kosik, Executive Director
Early Childhood Development Center
University of Notre Dame, 10 Child Care Center, Notre Dame, IN 46556
Fax: 574-631-7808 / Phone: 574-631-3344 / tkosik@saintmarys.edu
ECDC Tuition Payment Options and Parent Agreement for Tuition Payments

17-18 Extended SY, 18 Summer & 18-19 SY

17-18 Optional Extended School Year (ESY) Tuition Payment Options (5/21/18 – 6/7/18 – 3 weeks)
Families will be invoiced in early May for the 3-week (13 day) Extended School Year Program. Tuition can be paid in one of the following ways:

- **1 payment** – Remit the full ESY tuition amount on or before the 1st day of the ESY program (May 21, 2018).
- **2 payments** – Divide the total tuition amount in half paying one half by the 1st day of the ESY program (May 21) and the 2nd payment by Thursday May 31st.
- **3 Weekly payments** – Divide the total tuition amount into 3 equal payments paying in advance on the first day of each week (M – 5/21, T – 5/29 and M – 6/4).
- **Please note** – parents are not invoiced for Memorial Day and Friday June 8th when ECDC is closed.

Summer Tuition Payment Options:  (6/11/18 – 8/3/18 – 8 weeks)
Families will be invoiced in May for the 8-week Summer Program (SU). Tuition can be paid in one of the following ways:

- **1 payment** – Remit the full Summer Tuition amount on or before the 1st day of the SU program (June 11th).
- **2 payments** – Divide the total tuition amount in half paying one-half by the 1st day of the SU program June 11th, and the second half by Monday July 9th.
- **4 payments** - Divide the total tuition amount into 4 equal payments remitting as follows: June 11th, June 25th, July 9th, and July 23rd.
- **8 Weekly payments** – Divide the total tuition amount into 8 equal payments remitting, in advance, on Monday of each week beginning June 11th through July 30th.
- **Please note** – parents are not invoiced for July 4th when ECDC is closed.

Extended Summer Tuition Payment Options:  (8/6/18 – 8/10/18) – for this 1 week program tuition is due on or before August 6, 2018

Fall Tuition Payment Options:  (8/20/18 – 12/21/18)
Families will be invoiced in August for Fall Semester tuition.

- **1 payment** – Remit the full Fall Semester tuition amount on the 1st day of the SY program (August 20th).
- **2 payments** – Divide the total tuition amount in half remitting one half by the 1st day of the SY program (August 20th) and the second half by November 1st.
- **5 payments** – Divide the total tuition amount into 5 equal amounts remitting as follows: Aug 20th, Sept 1st, Oct 1st, Nov 1st, Dec 1st.
- **9 payments** – Divide the total tuition amount into 9 equal payments remitting as follows: Aug 20th, Sept 1st & 15th, Oct 1st & 15th, Nov 1st & 15th, Dec 1st & 15th.
- **18 Weekly payments (8/20 – 12/17/18)** – Divide the total tuition amount into 18 equal amounts remitting, **in advance**, on Monday of each week beginning Aug 20th through Dec 17th.
- **Please note** – parents are not invoiced for the W, TH and Fri of Thanksgiving week when ECDC is closed. ECDC is open on Labor Day due to ND/SMC holding classes and is also open during Fall Break due to staff members working. Parents are invoiced for these time periods.
- **Fall Semester “Gymnastics in Motion” Fees** - Please note that in September Fall Semester Gymnastic fees will be invoiced to your tuition account. At that time you may pay the full amount or add that to your regular payment plan, which will require you to recalculate your tuition payment amounts.

Parent paid tuition is used for ECDC teacher and program staff payroll and other program expenses (food, health insurance, etc.). It is necessary for families to remain current with tuition payments. We understand that at times families experience unexpected financial challenges. Please contact Terri Kosik, ECDC executive director at tkosik@saintmarys.edu promptly should you experience difficulties keeping current with ECDC tuition. Past due balances may result in disenrollment. Thank you for your cooperation with prompt tuition payments; it is truly appreciated.

**Important - Please complete and submit the attached required form indicating your ECDC tuition payment plan and agreement, thank you. Please keep this page for your reference, thank you.**
ECDC Parent Tuition Payment Agreement for Extended SY, 18 SU and/or 18-19 SY

Parent Names (please print) ____________________________________________________________________________________________________

Child(ren)'s Name (please print) ______________________________________________________________________________________________

This form is due by May 15th for Extended SY and 2018 Summer. This form is due by August 1 for 2018-19 SY.

Please submit one form per family for all relevant programs.

17-18 Optional Extended School Year (ESY) Tuition Payment Options (5/21/18 – 6/7/18 – 3 weeks)

Initial below the payment plan you will use to remit ESY tuition, thank you.

_____ 1 payment – Remit full ESY tuition on or before Monday May 21, 2018.
_____ 2 payments – Remit one half of the tuition on or before Monday May 21 and the second half on Thursday May 31.
_____ 3 Weekly payments – Remit 3 payments by the first day of each week as follows: 5/21, 5/29, & 6/4.
_____ N/A my child is not attending this program.

Summer Tuition Payment Options: (6/11/18 – 8/3/18 – 8 weeks)

Initial below the payment plan you will use to remit SU tuition, thank you.

_____ 1 payment – Remit full summer tuition amount on or before June 11th.
_____ 2 payments – Remit half of summer tuition by Monday June 11th and the second half by Monday July 9th.
_____ 4 payments – Remit 4 equal summer tuition payments by June 11th, June 25th, July 9th, and July 23rd.
_____ 8 Weekly payments – Remit 8 equal tuition payments on Monday of each week beginning June 11th – July 30th.
_____ N/A my child is not attending this program.

Optional Extended Summer Tuition Payment Options: (8/6/18 – 8/10/18) – for this 1 week program tuition is due on or before August 6, 2018.

Fall Tuition Payment Options: (8/20/18 – 12/21/18 – 18 weeks)

Initial below the payment plan you will use to remit SY tuition, thank you.

_____ 1 payment – Remit the full Fall Semester tuition amount on or before August 20th.
_____ 2 payments – Remit half of Fall Semester tuition by Aug 20th and the second half by November 1st.
_____ 5 payments – Remit 5 equal payments as follows: Aug 20th, Sept 1st, Oct 1st, Nov 1st, Dec 1st.
_____ 18 Weekly payments (8/20 – 12/17/18) – Remit 18 equal amounts beginning with the first Monday of Fall Semester, August 20th continuing each week through Monday December 17th.
_____ N/A my child is not attending this program.

• Fall Semester Gymnastics in Motion Fees – Please note that in September Fall Semester Gymnastics fees will be invoiced to your tuition account. At that time you may pay the full amount or add to your regular payment plan, which will require you to recalculate your tuition payment amounts.

Parent paid tuition is used for ECDC teacher and program staff payroll and other program expenses (food, health insurance, etc.). It is necessary for families to remain current with tuition payments. We understand that at times families experience unexpected financial challenges. Please contact Terri Kosik, ECDC executive director, at tkosik@saintmarys.edu promptly should you experience difficulties keeping current with ECDC tuition. Past due balances may result in disenrollment. Thank you for your cooperation with prompt tuition payments; it is truly appreciated.

My signature below indicates that I will pay ECDC tuition according to the guidelines above and as indicated by my initials above.

Parent Signature (required) ______________________________________________________________________________ Date ___________________
EARLY CHILDHOOD DEVELOPMENT CENTER
Saint Mary’s College and the University of Notre Dame

EMERGENCY INFORMATION

Name of Child ____________________________________________ Gender _______ Birthdate _____________

Mother or guardian ____________________________________________ Home Phone __________________________
Home Address/City/State/Zip ________________________________________________________________________
Business Name________________________________________________ Occupation__________________________ Work Hours _____________
Business Address/City/State/Zip ________________________________________________________________________
Work Phone_________________________ Cell Phone*_____________________ E-mail*_____________________

Father or guardian ____________________________________________ Home Phone___________________________
Home Address/City/State/Zip ________________________________________________________________________
Business Name________________________________________________ Occupation__________________________ Work Hours _____________
Business Address/City/State/Zip ________________________________________________________________________
Work Phone_________________________ Cell Phone*_____________________ E-mail*_____________________

*Please note: The majority of ECDC letters and notices to families will be sent via e-mail. ECDC will notify families of emergency school closures through School Reach Emergency Notification System via email, text & a recorded call to your cell phone. Please keep this information current with the ECDC office.

Important: Please indicate how you would like us to contact you during the school day regarding information about your child (injury, illness, etc.):
1st ___________________________ 2nd ___________________________ 3rd ___________________________

If either parent is a faculty member or student, please list school, department, and phone number of a secretary who would be able to reach you in an emergency:

School_________________________________Department_________________________Phone_____________________

Please list the name of a friend or relative who may be reached in case of an emergency. This individual may be asked to pick your child up from ECDC in the event of an illness, injury or emergency. It is a State Requirement that a LOCAL emergency person is listed.

Name ____________________________________________ Relationship to child____________________________
Address/City/State/Zip____________________________________________________Phone_____________________

PERSONS AUTHORIZED TO PICK UP MY CHILD

Authorized individuals will be required to show picture identification when picking up a child from ECDC. Under no circumstances will a child be released to anyone not known to the center without authorization from parents or guardians.

1) Name ____________________________________________ Relationship to child ___________________________
   Address/City/State/Zip_______________________________________________________Phone_____________________

2) Name ____________________________________________ Relationship to child ___________________________
   Address/City/State/Zip_______________________________________________________Phone_____________________

If a parent is denied permission to pick-up a child or has restricted pick-up, please provide the parent's name and details - and a copy of the court order.

Signature of Parent or Legal Guardian_________________________________________ Date___________________
I agree, and by my signature give consent that in case of an accident, injury or illness of a serious nature, my child will be given emergency medical care. I understand that I will be contacted immediately, or as soon as possible, should I be away from the phone numbers given with this form.

Child’s Name __________________________________________________________ Date of Birth _______________________

Child’s Physician*___________________________________________________ Phone _______________________

Address/City/State/Zip________________________________________________________________________

Child’s Dentist*_______________________________________________________ Phone _______________________

Address/City/State/Zip________________________________________________________________________

*If the name of a physician and/or dentist is not provided, the ECDC consulting physician and/or dentist (Dr. John Rice, M.D., Dr. Deanna O’Neil, D.D.S.) will be listed for you until you provide an alternate physician and/or dentist.

If, in an emergency, your child’s regular doctor cannot be reached, may we use John Rice, M.D., the consulting physician for the Early Childhood Development Center? Yes_____ No _____ If you answered no, which other physician do you prefer we call?________________________________________________________

Address __________________________________________ Phone ______________________

Do you have a preference regarding the hospital we would take your child to in case of a medical emergency? Yes_____ No_____ If yes, please indicate your hospital of preference ____________________________

Name of child’s private health insurance & policy number:___________________________________________________
or
Medicaid or Hoosier Healthwise number for your child and primary adult_____________________________________

__________________________________________________________

Signature of Parent or Legal Guardian ____________________________ Date ______________________

REMINDER: Please update information contained on this form when changes occur.
The information on this form is strictly confidential and will be used by the teacher to help her/him better understand and work with your child. (key: SY=school year, SU=summer)

Child's Name_____________________________ Date of Birth__________ Child's Present Age____

What is the name you want on your child’s locker & cubbie?____________________________________

Family -
Father’s Name_________________ Mother’s Name_________________

Please list all children in the family and their ages________________________________________________

Name of person(s) who has legal custody of child________________________________________________

Name of person(s) child lives with______________________________________________________________

If your child lives across two households, would you like duplicate items posted on your locker? Yes___No___
(SY only - Most communication will be via email, but picture order forms, fundraising materials, etc. will be posted on lockers)

Please list names of individuals (including emergency contacts) authorized by you or your family to have access to health information about this child ____________________________________________________________

Please indicate your child’s ethnicity (this information is used for grant reporting purposes only):

- African American
- Native American/Alaska Native
- Asian
- Caucasian
- Pacific Islander/Native Hawaiian
- Latino
- Other __________________

Child’s primary language________________________ Second language__________________________

Does your child understand English?__________________________________________________________

For parents of children that are learning English and have a primary language other than English, please provide teachers with basic vocabulary words in the child’s primary language to support engagement throughout the day and routines (Please write words phonetically to help teachers with pronunciation):

Words child uses to refer to parents/family members_____________________________________________

Basic body parts__________________________________________________________________________

Bodily functions (e.g. go to the bathroom, potty, tinkle, bowel movement)________________________

<table>
<thead>
<tr>
<th>Hi</th>
<th>Water</th>
<th>Music/Dance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goodbye</td>
<td>Milk</td>
<td>Puzzles</td>
</tr>
<tr>
<td>Play</td>
<td>Rest time</td>
<td>Blocks</td>
</tr>
<tr>
<td>Eat</td>
<td>Story/Book</td>
<td>Baby</td>
</tr>
<tr>
<td>Drink</td>
<td>Outside</td>
<td></td>
</tr>
</tbody>
</table>

Parents Be Back Soon ____________________________

*Feel free to attach a separate page if there are other words/phrases that you feel may be helpful.
**Development and Information**

**Diet - Please check all that apply:**

- My child is a vegetarian
- I would like my child to be served a vegetarian entrée for lunch
- Due to religious beliefs, my child does not eat ______________________________
- My child has dietary restrictions due to food allergies (a doctor’s signature is required on the medical plan form and please contact ECDC to arrange a time to review breakfast/lunch/snack menus)

My child receives/received special services (e.g., First Steps, Speech Therapy, OT, PT). Yes___ No____
If yes, please explain__________________________________________________________

Pre-K only: Does your child nap?___ If yes, how long and often?___________________ Does your child tire easily?_____, please explain__________________________________________________________

**Toileting – for preschool ages only unless there is information you would like to share:**

To what degree have bladder and bowel control been established?________________________________________
Can your child help her/himself at the toilet?________________________________________________________
Needs what kind of bathroom assistance?__________________________________________________________
Additional comments regarding toileting______________________________________________________________

**Past Experiences -**

**SU School Agers:** What grade has your child finished?____ Your child’s school:________________________
Has your child attended a recreational summer day camp program before?__________________________

**Pre-K & Kindergarten:** What type of program(s) has your child attended in the past?________________________
Name of the program(s) ___________________________ Length of involvement____________________________
Please describe your child’s overall reaction to group experiences __________________________________________

Describe your child in one or two words ______________________________________________________________
Characteristic behavior in a new situation _____________________________________________________________
Your child’s favorite activities and interests __________________________________________________________
Your child’s favorite books _______________________________________________________________ 
Your child’s favorite indoor games ___________________________ ___________________________ 
Your child’s favorite outdoor games ___________________________ ___________________________ 

Describe any fears your child has of which we should be aware?________________________________________
Parents’ methods of overcoming fears ________________________________________________________________

**SY only:** In what ways would you like your child’s ECDC experiences to contribute to his/her growth and development? ________________________________________________________________
Is there anything about your child that concerns you?______________________________________________

__________________________________________________________________________________________

Have there been any unusual occurrences concerning your child that you feel we should be aware? (e.g. premature birth, auto accident, severe illness, death in the family, etc.)______________________________________________

__________________________________________________________________________________________

Do you or your child have any special talents, interests, hobbies, or skills you could share with the children at ECDC?__________________________________________________________________________________________

SY only: Would you be available to help with special field trips? (applies to children enrolled in the 4’s, 4/5’s & kindergarten groups)__________________________________________________________________________________________

SY kindergarten only: What would be a convenient day of the week and/or time to visit the kindergarten class to share your talent, hobby, interest or career with the class?__________________________________________________________________________________________

Please feel free to attach an additional page if more space is needed to share any information that will help us better understand and work closely with your child and your family.

**ECDC CLASS DIRECTORY** – An ECDC class directory will be emailed to parents at the beginning of each semester and will include parents’ names, home addresses, home phone numbers and email addresses. We hope this directory is helpful as you schedule play dates and carpools. **The ECDC directory is compiled from the information you supplied on your registration form.**

_____ I give permission for my information to be included in the ECDC class directory.

_____ Our address has changed since we registered - please use the address on our emergency information form and not the address on the registration form.

_____ We prefer our cell phone numbers are listed on the directory rather than our home phone number.

Signature of Parent/Guardian _____________________________ Date _____________________________

**ECDC PARENT HANDBOOK/TUITION** - I have read the ECDC Parent Handbook (available on the ECDC website at [http://www.nd.edu/~ecdcd/parentsinfo.html](http://www.nd.edu/~ecdcd/parentsinfo.html)) and understand the policies and procedures outlined within. I agree to follow the ECDC tuition policy on page 32 of the Parent Handbook and understand that tuition must be paid in advance.

Signature of Parent/Guardian _____________________________ Date _____________________________

**DEVELOPMENTAL SCREENINGS** (This applies to school year enrollment only) – ECDC uses the Ages & Stages Developmental Screening (ASQs) to monitor children’s development when questions occur regarding learning or development. ASQs are administered by someone familiar to your child such as their ECDC teacher, program director or family resource specialist. The ASQ results are shared with parents in a confidential manner. I grant permission for my child to receive the ASQ Developmental Screening and/or ASQ Social Emotional (ASQ-SE) Developmental Screenings.

Signature of Parent/Guardian _____________________________ Date _____________________________
AUTHORIZATION TO SHARE HEALTH INFORMATION – Early Childhood Development Center recognizes that health and medical information about your child is confidential. All records in your child’s file (including health, development and contact information) are kept in a locked cabinet in the office and access to this cabinet is limited. All information pertaining to the admission, development, assessment, family and/or discharge of a child is confidential and will only be shared with teachers and staff on a “need to know” basis.

By signing below, I give full time staff and teachers permission to have access to ________________________’s health records.

Signature of Parent/Guardian__________________________________________ Date____________________

CHILD GUIDANCE/DISCIPLINE POLICY/COMMUNICATION - I have read and/or discussed the Adlerian philosophy of teacher-child interactions and discipline implemented by the Early Childhood Development Center’s teaching staff. I understand that choices and logical consequences are utilized rather than punishment. Children are provided with encouragement rather than praise. According to state regulations, I understand that any disciplinary action taken will be communicated to the parents and noted in my child’s record. I also understand that I will be notified of all significant occurrences or problems which affect my child. This includes, but is not limited to, notices regarding accidents, injuries, first aid, possible exposure to communicable diseases and prior notification regarding field trips.

Signature of Parent/Guardian__________________________________________ Date____________________

PHOTOGRAPHY PERMISSION – I grant permission for photographs of my child to be taken at ECDC and possibly used in the following ways:

_____ for ECDC classroom use by teachers (to document learning and activities)
_____ for SMC/ND student projects (names will not be used)
_____ for media/marketing purposes (names will not be used)

Signature of Parent/Guardian__________________________________________ Date____________________

SUNSCREEN PERMISSION (Parent Supplies) – I give permission for teachers to apply sunscreen to my child to help prevent possible sunburn. I understand that I must provide the sunscreen, and due to accreditation standards, I will provide a sunscreen that is a minimum SPF 15 and has UVA/UVB protection. ECDC staff will apply/or facilitate application of sunscreen as needed before outside activities (primarily May through September).

Signature of Parent/Guardian__________________________________________ Date____________________

INSECT REPELLENT (ECDC Supplies) – I give permission for teachers to apply a mild insect repellant to my child prior to outdoor activities (e.g., nature activities/walks at parks such as Potato Creek Park, St. Mary’s College-Nature Walks, Madeline Bertrand Park, Bendix Park, Clay Park, Sarrett Nature Center, etc.). The insect repellant will be supplied by ECDC and will be applied by ECDC staff. Due to accreditation standards, the repellant used will contain DEET and will be applied no more than once per day.

Signature of Parent/Guardian__________________________________________ Date____________________
# EMERGENCY HEALTH INFORMATION AND MEDICAL PLAN

**All Families Need to Complete Annually**

## PART 1 - Parent or Guardian to Complete.

<table>
<thead>
<tr>
<th>Student’s Name:</th>
<th>Last</th>
<th>First</th>
<th>Middle</th>
<th>Gender</th>
<th>DOB</th>
</tr>
</thead>
</table>

My child has a medical condition that may affect his or her school day: [ ] NO [ ] YES *(if YES, please complete Part 2, 3, 4)*

____________________
Parent/Guardian’s Name (please print)

____________________
Parent/Guardian’s Signature

Date

## PART 2 – Complete all boxes that apply to your child.

### ALLERGIES

- **Allergy type:**
  - [ ] Food
  - [ ] Medication
  - [ ] Bee sting
  - [ ] Other (list)

- **Reactions:**
  - [ ] Coughing
  - [ ] Hives
  - [ ] Rash
  - [ ] Difficulty breathing
  - [ ] Local Swelling
  - [ ] Wheezing
  - [ ] Generalized swelling
  - [ ] Nausea
  - [ ] Other

- **Currently prescribed treatments to be used IN SCHOOL**
  - [ ] Oral antihistamine (Benadryl, etc.)
  - [ ] EpiPen
  - [ ] Other

### ASTHMA

- **Triggers:**
  - [ ] Exercise
  - [ ] Environmental
  - [ ] Other (list)

- **Physical Restrictions:**
  - [ ] None
  - [ ] Self-limits
  - [ ] Other

- **Symptoms or reactions:**
  - [ ] Chest tightness/discomfort/pain
  - [ ] Difficulty breathing
  - [ ] Throat itch/tightness/soreness
  - [ ] Coughing
  - [ ] Hoarseness
  - [ ] Wheezing
  - [ ] Other

- **Currently prescribed treatments to be used IN SCHOOL**
  - [ ] Inhalers
  - [ ] Oral antihistamines
  - [ ] Oral steroids
  - [ ] Oral bronchodilator
  - [ ] Peak flow monitoring

- **Date of last hospitalization related to asthma**

### DIABETES

- **Currently prescribed treatments to be used IN SCHOOL**
  - [ ] Insulin
  - [ ] Syringe
  - [ ] Pen
  - [ ] Pump
  - [ ] Blood sugar testing
  - [ ] Glucagon
  - [ ] Oral medication(s)

- **List medication(s)**

### SEIZURE DISORDER

- **Type of seizure:**
  - [ ] Absence (staring/unresponsive)
  - [ ] Complex partial
  - [ ] Generalized tonic-clonic (grand mal/convulsive)
  - [ ] Other (explain)
SEIZURE DISORDER continued:

Physical restrictions: ☐ NO ☐ YES

Medications needed IN SCHOOL ☐ NO ☐ YES List medication(s) ________________________________________

Date of last seizure _______________________________ Length of seizure _______________________________

☐ OTHER HEALTH CONDITIONS

☐ Physical condition (be specific) ____________________________________________
☐ Other (be specific) ________________________________________________________

Physical restrictions: ☐ NO ☐ YES

Medications needed IN SCHOOL ☐ NO ☐ YES List medication(s) ________________________________________

Special procedures required IN SCHOOL ☐ NO ☐ YES (explain) ______________________________

☐ VISION CONDITIONS ☐ HEARING CONDITIONS

☐ Contacts ☐ Glasses ☐ Hearing aid(s) ☐ Other

☐ Other _________________________________________ ☐ Other _________________________________________

PART 3 – PHYSICIAN’S SIGNATURE REQUIRED if parent or guardian indicates medical condition(s) requiring medications, restrictions, monitoring and/or food substitutions.

Symptoms to watch for:

When to use prescribed medication(s) (please list medication/dose/route):

When to call emergency health professional:

☐ This child has food allergies. Please allow parent/guardian to provide store bought substitutes as needed.

Other notes:

Physician’s signature __________________________________________ Date __________________

Completed form may be faxed to ECDC-ND at 574-631-7808 or ECDC-SMC at 574-284-5344

PART 4 – EMERGENCY CONTACTS

1. Call 911.
2. Dr. ___________________________ Phone Number: ___________________________
3. Parent/Guardian _________________ Phone Number: ___________________________
4. Parent/Guardian _________________ Phone Number: ___________________________
5. Emergency Contacts:
   Name/Relationship ___________________________ Phone Number(s)
   a. ________________________________________
   b. ________________________________________

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian’s Signature __________________________________________ Date __________________

EARLY CHILDHOOD DEVELOPMENT CENTER
PRESCHOOL / KINDERGARTEN / CHILD CARE CENTER HEALTH RECORD
State Form 49969 (R3 / 11-11)

*All child physicals must be submitted to the office no later than 30 days after their first day of enrollment.

<table>
<thead>
<tr>
<th>Name of child (last, first)</th>
<th>Date of birth (month, day, year)</th>
<th>Date of admission (month, day, year)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address (number and street, city, state, ZIP code)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Child lives with (relationship)</th>
<th>Name</th>
<th>Telephone number</th>
</tr>
</thead>
</table>

### MEDICAL HISTORY

<table>
<thead>
<tr>
<th>Communicable Disease</th>
<th>Month / Year</th>
<th>Condition</th>
<th>Explain if present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubella (German Measles)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chickenpox</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scarlet Fever</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whooping Cough</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### PHYSICAL EXAMINATION

<table>
<thead>
<tr>
<th>Date of exam (month, day, year)</th>
<th>Age of child</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Skin</th>
<th>Heart</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lymphnodes</td>
<td>Lungs</td>
</tr>
<tr>
<td>Eyes</td>
<td>Abdomen</td>
</tr>
<tr>
<td>Ears</td>
<td>Genitilia</td>
</tr>
<tr>
<td>Nasopharynx</td>
<td>Skeleton</td>
</tr>
<tr>
<td>Teeth and Mouth</td>
<td>Other:</td>
</tr>
</tbody>
</table>

Note any unusual findings:

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Does this child have any health condition that would be hazardous either to the child or to the other children in a group setting as a result of participation in normal activities (including sports)?

☐ Yes  ☐ No  If yes, what modification of normal activities would be necessary to protect the child and the child’s classmates:

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Have you prescribed any medications or special routines which should be included in the center’s plans for this child’s activities?

☐ Yes  ☐ No  If yes, please explain:

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--------------------------------------------------------------------------------------------------

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HISTORY OF IMMUNIZATIONS

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>(Enter the month, day and year each immunization was given.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP/DT*</td>
<td>Diphtheria, Tetanus, Pertussis</td>
</tr>
<tr>
<td>Hib</td>
<td>Haemophilus influenza type b</td>
</tr>
<tr>
<td>IPV*</td>
<td>Polio</td>
</tr>
<tr>
<td>MMR*</td>
<td>Measles, Mumps, Rubella</td>
</tr>
<tr>
<td>Varicella*</td>
<td>Chickenpox Or Chickenpox Disease (Month/Year):</td>
</tr>
<tr>
<td>PCV*</td>
<td>Pneumococcal Conjugate</td>
</tr>
<tr>
<td>Hep B*</td>
<td>Hepatitis B</td>
</tr>
<tr>
<td>Hep A**</td>
<td>Hepatitis A</td>
</tr>
<tr>
<td>RGE</td>
<td>Rotavirous</td>
</tr>
<tr>
<td>Flu</td>
<td>Influenza</td>
</tr>
</tbody>
</table>

ADDITIONAL NOTES AND INSTRUCTIONS

*Indiana law requires all children attending licensed childcare facilities to be immunized against this disease.
**Hep A is required for kindergarten enrollment.

STATEMENT OF EXEMPTION TO IMMUNIZATION LAW

IN THE EVENT THAT A VACCINE-PREVENTABLE DISEASE TO WHICH CHILDREN ARE SUSCEPTIBLE OCCURS IN THE PROGRAM, UNDER-IMMUNIZED CHILDREN WILL BE PROMPTLY EXCLUDED PER STATE GUIDELINES. (ECDC tuition continues during exclusion)

MEDICAL EXEMPTION: The physical condition of the above named person is such that immunization would endanger life or health or is medically contraindicated due to other medical conditions.

Signed __________________________ Date __________________________
Physician

Medical exemption to the following vaccine(s):

DTaP  IPV  MMR  VAR  PCV  HepB  Hep A

RELIGIOUS EXEMPTION: Parent or guardian of the above named person or the person himself/herself is an adherent to a religious belief opposed to immunizations.

Signed __________________________ Date __________________________
Parent / guardian

Religious exemption to the following vaccine(s):

DTaP  IPV  MMR  VAR  PCV  HepB  Hep A

Name of physician / nurse practitioner completing form (please print)  
Telephone number

Signature of physician / nurse practitioner

Completed forms may be faxed to:
ECDC at Notre Dame  Phone: (574) 631-3344  Fax: (574) 631-7808
ECDC at Saint Mary’s  Phone: (574) 284-4693  Fax: (574) 284-5344