

**Martha & Mary Children's Services**  
**M&M Kids' Club - Silverdale**  
**REGISTRATION FORM**

Child's Name: \_\_\_\_\_ School: \_\_\_\_\_

Start Date: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Gender: \_\_\_\_\_ Age: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City/Zip: \_\_\_\_\_

Father: \_\_\_\_\_ Mother: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

City/ST/Zip: \_\_\_\_\_ City/ST/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

In case of emergency (if parents cannot be reached), please contact the following who have my permission to remove my child from the center:

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

City/ST/Zip: \_\_\_\_\_ City/ST/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

City/ST/Zip: \_\_\_\_\_ City/ST/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## HEALTH INFORMATION RECORDS

In the event my child is injured or becomes seriously ill, and no parent or responsible party listed can be reached, my child's physician is:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of last physical (**REQUIRED**): \_\_\_\_\_

Does your child have any allergies? (Circle) YES NO

If yes, please list (be sure to fill out the Allergy Information Form):

1. \_\_\_\_\_

2. \_\_\_\_\_

Does your child take any medications? (Circle) YES NO

If yes, please list (be sure to fill out the Consent to Administer Medication Form):

1. \_\_\_\_\_

2. \_\_\_\_\_

Does your child have any special health or developmental needs of which we should be aware?

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## PARENT AUTHORIZATION

I give permission to Martha and Mary Children's Services to transport my child to and from the site on field trips and other activities. I give the Martha and Mary staff authorization to administer first aid to my child as necessary.

In the event I cannot be reached, I give the Martha and Mary staff permission to obtain medical care for my child. I expect that a conscientious effort will be made to locate my designees or myself. I will accept any expenses incurred.

I give permission for my child to be photographed on field trips and in the classroom, and understand that Martha & Mary Children's Services will attempt to receive my consent for any photos used for publicity purposes.

I acknowledge that I have received and read the parent information packet for the M&M Kids' Club and agree to abide by the policies stated therein.

Parent signature: \_\_\_\_\_ Date: \_\_\_\_\_

Martha & Mary Children's Services  
**CONSENT FOR EMERGENCY TREATMENT**

I hereby give my permission that my child, \_\_\_\_\_ may be given emergency treatment by a qualified staff member of Martha & Mary Children's Services.

I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

I further authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child be a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health and I cannot be contacted. I waive my right of informed consent to such treatment.

Child's Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Dentist: \_\_\_\_\_ Dentist's Phone: \_\_\_\_\_

Dentist's Address: \_\_\_\_\_

Hospital: \_\_\_\_\_ Medical Insurance: \_\_\_\_\_

Insurance #: \_\_\_\_\_ Chronic Illnesses: \_\_\_\_\_

Regular Medications: \_\_\_\_\_

Date Of Last Tetanus (DPT) Immunization: \_\_\_\_\_

Allergies (Drugs Or Other): \_\_\_\_\_

Other Pertinent Data: \_\_\_\_\_

Child's Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Mother: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Father: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Emergency Contacts: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_  
Signature Of Parent

\_\_\_\_\_  
Date

Martha & Mary Children's Services  
**MEDICATION POLICIES/CONSENT TO ADMINISTER**

*Our policy is: All medications will be given only with prior written consent of the child's parent/legal guardian. Other criteria will be required as defined below.*

**Prescription medications** must be in the original container from the pharmacy and labeled with:

1. child's name (first and last, middle initial if necessary)
2. medication name
3. dosage amount
4. frequency
5. length of time (e.g. days)
6. prescribing physician

**Non-prescription medications** (over-the-counter drugs) such as:

1. antihistamines
2. non-aspirin fever reducers/pain relievers
3. non-narcotic cough suppressants
4. decongestants
5. anti-itching ointments
6. diaper ointments
7. sunscreen
8. vitamins

We will give a child nonprescription medications when:

1. the medication is in its original container, and
2. if the dose and frequency is stated on the label, and
3. the medication is dose appropriate for the age of the child as prescribed on the label of the original container

**All deviations from the label instructions must be accompanied with written consent from a parent and written instructions from a legally authorized health care provider.**

Physician's instructions will include:

1. child's name (first, last and middle initial if necessary)
2. the dose and frequency
3. length of time (e.g. days)

**\*\*NO MEDICATION MAY BE GIVEN IN FOOD OR BOTTLES\*\***

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**CONSENT TO ADMINISTER MEDICATION**

NAME OF CHILD: \_\_\_\_\_

MEDICAL PROBLEM: \_\_\_\_\_

NAME OF MEDICATION: \_\_\_\_\_

START DATE: \_\_\_\_\_ STOP DATE: \_\_\_\_\_

AMOUNT TO BE GIVEN: \_\_\_\_\_ TIMES OF DAY: \_\_\_\_\_

SPECIFIC INSTRUCTIONS: \_\_\_\_\_

ANTICIPATED SIDE EFFECTS: \_\_\_\_\_

CHILD ALLOWED TO SELF ADMINISTER MEDICINE UNDER STAFF SUPERVISION?: \_\_\_\_\_

PARENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



Martha & Mary Children's Services  
**ALLERGY INFORMATION FORM**

Child Name: \_\_\_\_\_

Allergy: \_\_\_\_\_

Reaction: \_\_\_\_\_

Symptoms: \_\_\_\_\_

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What to do if symptoms show or allergic reaction is suspected: \_\_\_\_\_

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Other important information: \_\_\_\_\_

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Allergy: \_\_\_\_\_

Reaction: \_\_\_\_\_

Symptoms: \_\_\_\_\_

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What to do if symptoms show or allergic reaction is suspected: \_\_\_\_\_

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Other important information: \_\_\_\_\_

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**Martha & Mary Children's Services**  
**FINANCIAL AGREEMENT**  
**PRIVATE PAY**

1. The undersigned agrees that in consideration of admission to Martha & Mary Children's Services and the rendering of services to the child, the family is obligated to pay all charges incurred in accordance with the payment regulations and current rate schedules of Martha & Mary Children's Services. The rate includes the cost of daily care and all meals for children over the age of one year, except when severe allergies preclude the Center meeting the child's food needs. Certain other charges (including, but not limited to diapers, mats, late payments, ten hour fees and space hold fees) shall be billed on the facility statement. The current rate schedule is attached.

2. Upon application, an advance payment of 50% of one month's tuition is required. This payment is applied to the first month's charges, and is non-refundable if the child does not attend. Payments are due upon receipt of statement each month for monthly services. Credit is not extended unless specifically arranged for in advance and approved by the Director. A late charge is added to accounts not paid in full by the 25th of the month. Accounts not made current by the last day of the month are in default. At that time, the child's enrollment will be terminated until full payment is made. A new initial registration fee will be required before enrollment may continue. Past due accounts bear interest in the amount of 12% per annum. Should the account be referred to an attorney for collection, the undersigned agrees to pay reasonable attorney's fees and all collection expenses. In the event a family voluntarily terminates enrollment, two weeks advance notice must be given.

3. SPACE HOLD. I have been fully informed of and understand the Center's policy on space hold. In the event that the child is removed for one week or more of consecutively scheduled days, the family incurs a daily charge to guarantee the availability of a slot until the Center has been notified otherwise. In the event the space hold fee is not paid, the slot may not be available when the child may require readmission.

The undersigned has read the foregoing and agrees to all of the conditions stated and accepts its terms. A copy will be issued upon request.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Signature of Director

\_\_\_\_\_  
Date

**Martha & Mary Children's Services**  
**FINANCIAL AGREEMENT**  
**SUBSIDISED PAY**

1. Where other parties such as state or federal agencies (DSHS) pay a portion or all of the childcare charges, the family hereby agrees to pay their participation of the charges, or all charges for any period the child is determined to be ineligible for the program, and all charges incurred which are properly charged toward the child under such programs.
  
2. In order to maintain enrollment, all co-payments and any other applicable fees must be paid in full no later than the last business day of the month. Payments made after the 25<sup>th</sup> of the month will include a \$15.00 late payment charge. Payments not paid by the end of the month will result in termination of enrollment. DSHS will be notified of such an occurrence.
  
3. Attendance must be consistent with DSHS authorization. Absences exceeding five per month may result in termination of enrollment. DSHS will be notified of such an occurrence.
  
4. Reauthorization of eligibility must be received from DSHS before the current end date of authorization. Enrollment of children not current will be terminated until such time as proof of eligibility is provided.
  
5. It is the sole responsibility of the parent/guardian to ensure that coverage with DSHS is kept current and up to date. Where activity fees are charged, it is the responsibility of the parent/guardian to notify DSHS. Any activity fees or extracurricular activities not covered by DSHS shall be the responsibility of the parent/guardian.

The undersigned has read the foregoing and agrees to all of the conditions stated and accepts its terms. A copy will be issued upon request.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Signature of Director

\_\_\_\_\_  
Date

Reviewed for compliance by: \_\_\_\_\_

Staff Signature

Date: \_\_\_\_\_ Exemption: YES  NO   
(see back)



## CERTIFICATE OF IMMUNIZATION STATUS

Washington State Law (RCW 28A.210.160) requires that all children have a completed Certificate of Immunization Status on file at the school, preschool or a child care facility that they attend. A chart showing which vaccines should be given and when, is printed on the other side of this form.

Child's Last Name	First Name	Sex	Birthdate
		<b>F M</b>	
Parent/Guardian Name			

Immunization	Type of Vaccine	Dose	Date Given		
			Month	Day	Year
<b>DTaP/DTP/ -DT/Td</b>  Diphtheria, Tetanus, Pertussis		<b>1</b>			
		<b>2</b>			
		<b>3</b>			
		<b>4</b>			
		<b>5</b>			
<b>POLIO</b>  OPV by mouth, IPV by injection		<b>1</b>			
		<b>2</b>			
		<b>3</b>			
		<b>4</b>			
<b>HIB</b>  Haemophilus Influenzae B		<b>1</b>			
		<b>2</b>			
		<b>3</b>			
		<b>4</b>			

Immunization	Type of Vaccine	Dose	Date Given		
			Month	Day	Year
<b>MMR</b>  <u>M</u> easles (Rubeola), <u>M</u> umps & <u>R</u> ubella	MMR	<b>1</b>			
	MMR	<b>2</b>			
	MMR				
	MEASLES				
	MUMPS				
	RUBELLA				
<b>HEP B (HBV)</b> Hepatitis B		<b>1</b>			
		<b>2</b>			
		<b>3</b>			
<b>VARICELLA</b> (Chickenpox)	VACCINE	<b>1</b>			
		<b>2</b>			
	DISEASE	<b>YES</b>		<b>NO</b>	
<b>OTHER VACCINES</b>					

➔ I certify that the information provided here is correct and verifiable ➜

**X** \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent or Guardian

# Immunization Entry Requirements for Schools, Preschools and Child Care Facilities ✕

Vaccines are listed under the routinely recommended ages. Shaded bars indicate range of acceptable ages for vaccination.

Age → Vaccine ↓	Birth	2 Months	4 Months	6 Months	12 Months	15 Months	18 Months	4-6 Years	11-12 Years	14-16 Years	
Hepatitis B **  Diphtheria, Tetanus, Pertussis  H. Influenzae type b  Polio  Measles, Mumps, Rubella	Hep B-1										
			Hep B-2		Hep B-3						
			DTP	DTP	DTP	DTP or DTaP at 15+ Mo			DTP or DTaP	Td **	
			Hib	Hib	Hib	Hib					
			Polio	Polio	Polio				Polio		
					MMR				MMR	or	MMR

✕The above schedule was recommended and approved January 1, 1995 by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics and the American Academy of Family Physicians. Footnotes of this schedule provide more information about vaccines and when they can be given. They are reprinted in the Immunization Manual for Schools, Preschools and Child Care Facilities, which can be found at most schools and Local Health Departments. Although there are more medically current recommended schedules, the January 1995 schedule is the only one required by Washington State Immunization Law.

\*\* Effective September, 1997

## Statement of Exemption to Immunization Law

**NOTICE:**

Your Child can be exempted (excused) from immunization for medical, personal or religious reasons. However, if there is an outbreak of a vaccine-preventable disease that your child has not been immunized against, she or he can be excluded from school, preschool or child care until the outbreak is over.

**Medical Exemption**

I certify that the child named on this form is medically exempted from the requirement for the following vaccine(s):

\_\_\_\_\_ Until \_\_\_\_\_  
 Vaccine(s) Date

\_\_\_\_\_ Date  
 Type or Print Physician's name Date

\_\_\_\_\_  
 Physician's Signature

**Personal Exemption**

**Religious Exemption**

I am opposed to immunization. I understand that my child can be excluded from attendance during an outbreak

I do not want my child to receive the following vaccine(s):

\_\_\_\_\_

\_\_\_\_\_ Date  
 Vaccine(s) Signature of Parent or Guardian

**Documentation of Immunity**

I certify that the child named on this form has laboratory evidence of immunity to measles/mumps/rubella (please circle).

Attach TITER results

\_\_\_\_\_

TYPE or PRINT Physician's Name

\_\_\_\_\_ Date  
 Physician's Signature or Stamp