



ENROLLMENT PACKET

Child's Name _____

The following items **must** be given to the FCC Provider **PRIOR** to the first day of care:

- Family Child Care Registration Form

Please attach:

- shot record
- health assessment
- PPD dated within 1 year (children 12 months and older)

- Child's Information Sheet

- Field Trips
- Transportation
- Water play

- Consent form for Insect Repellent, Sunscreen, & Diaper Ointment and Medication Authorization form

- Photo Release Form

- Family Care Plan (Dual Military and Single Parents only)

CHILD'S INFORMATION SHEET

*** Immunizations must be current. Parents must supply the provider with a copy of the child's shot record before any child care services begin. ***

CHILD'S NAME: _____ Birth Date: _____

Date of Enrollment: _____

1. Persons not permitted to contact the child:

**Please attach any necessary legal documentation (i.e. TRO's, custody paperwork, etc.)

2. Child's Doctor: _____ Phone: _____

3. Child's Dentist: _____ Phone: _____

4. Other children in family (Name, Age and Sex of each)

5. Other adults in family and relation to child:

6. Please give any information concerning your child that will be helpful to the FCC Provider:

Play Habits: _____

Eating Behavior: _____

Sleeping Patterns: _____

Fears: _____

Likes/Dislikes: _____

Favorite food, toys, etc.: _____

Special Words: _____

7. Previous experiences with child care (places and dates): _____

8. List any chronic problem (and dates) that your child has. EX: Seizures, Asthma, Drug Reactions, etc. _____

Describe symptoms and give instructions for any above mentioned conditions:

9. Describe any allergies including foods which have caused adverse reactions or any food NOT to be given to the child for health or religious reasons: _____

**FAMILY CHILD CARE
PARENT PERMISSION SLIP**

My child _____ has permission to attend the field trip to

(Name)

_____ on

(field trip location)

_____ at _____. I understand that transportation will be by

(date)

(time)

_____.

(mode of transportation- bus, private car, etc.)

Signature of Parent or Legal guardian

Date

**FAMILY CHILD CARE
PARENT PERMISSION SLIP**

My child _____ has permission to leave the FCC home for reasons to include, but not limited to, walks within the housing area, walks to and from schools, trips to neighborhood parks, 7 day mini marts and community centers.

Signature of Parent or Legal guardian

Date

FAMILY CHILD CARE PROVIDER

TRANSPORTATION FORM

I, _____ hereby authorize _____
(Parent) (Provider)

to transport my child, _____ in her privately owned vehicle or other means of transportation as necessary for field trips, outings, back-up care, etc.

Parents will be notified in advance of any planned activity that requires their child to be transported.

In a situation, where the child(ren) are transported to a certified back-up provider's home, parents will be notified as soon as possible.

_____ I am satisfied based on my review, that the FCC Provider has adequate automobile insurance coverage. The provisions of the automobile insurance policy specifically covers injuries and deaths arising out of an automobile accident occurring during the course of conducting child care business.

Signature of Parent or Legal guardian

Date

FAMILY CHILD CARE

FAMILY CHILD CARE

AUTHORIZATION FOR DISPENSING MEDICATION

CYTP MAY NOT ACCEPT NOR ADMINISTER ANY FORM OF MEDICATION WITHOUT THE THOROUGH COMPLETION OF THIS AUTHORIZATION.

Medication procedures will be administered only to children in Children, Youth and Teen Programs (CYTP) and only by the CYTP staff. The medication or special therapeutic procedures must be prescribed by a physician and there must be no other reasonable alternative to the medical requirement for the child. Authorized ointments may be applied by CYTP staff. Medication will be administered only to children enrolled in full day CYP (CDC Full Day program and FCC homes) and only by trained personnel/Providers. The medications or special therapeutic procedures must be prescribed by a physician, and there must be no other reasonable alternative to the medical requirement for the child. Parents/guardians must administer all oral medication for the first 48 hours. Tylenol and like products will only be administered following immunizations, and only with a current prescription. Prescribed medications must be on the approved medication list to be administered.

Prescribed medications can be given only upon the written order of a physician. A medication container label bearing the prescribing physician's name may be accepted as the physician's order. All medications must be clearly labeled with: 1) The Child's Name, 2) The Name of the Medication, 3) The Name of the Prescribing Physician, 4) Directions for administration. Medication may not be more than 30 days old, with the exception of medication for asthma or bee stings, which is approved for administration on an "AS NEEDED" basis.

TO BE COMPLETED BY THE CHILD'S SPONSOR OR GUARDIAN:

I authorize _____ to administer to _____
(CYTP Facility Name) (Child's Name)
the medication as outlined below.

Name of Medication:	
Dosage:	
Any Known Side Effects:	
Time/s of Administration:	
Dates of Medication:	
Medication Prescribed for the Treatment of:	
Name of Prescribing Physician:	
Signature of Sponsor/Guardian:	Date:

CYTP's Administering Medication form is required for all medications, lotions or ointments, and must be completed, dated and signed by the parent/guardian prior to CYTP accepting or administering any of the items

on the **approved medication listing**. This form must be updated at least monthly by parents to ensure we have current up-to-date information for your child.

INSECT REPELLENT

Parents must supply the insect repellent they would like the FCC Provider to apply. The time will be logged by the Provider on your child’s Administering Medication form each time the repellent is applied.

Please apply insect repellent on my child as follows:

- Only when requested by the parent
- As needed

SUNSCREEN

Parents must supply the sunscreen they would like the FCC Provider to apply. The sunscreen will be applied once daily after nap and/or before splash days. The time will be logged by the Provider on your child’s Administering Medication form each day. Parents will be responsible to apply sunscreen prior to coming to the FCC home each day.

Please apply sunscreen on my child as follows:

- For afternoon outdoor play
- For water play or beach/pool field trips
- As needed

DIAPER OINTMENT/TOPICAL CREAM

Parents must supply the diaper ointment they would like the FCC Provider to apply. The time will be logged by the Provider on your child’s Administering Medication form each time the ointment is applied.

Please apply diaper ointment on my child as follows:

- Only when requested by the parent
- As needed

PARENT SIGNATURE

DATE

CHILD’S NAME

FCC PROVIDER’S NAME

DRUGS APPROVED FOR ADMINISTRATION

1. The following list of prescribed medications is approved for administering within MCBH, Children, Youth and Teen Programs (CYTP), as designated by United States Naval Hospital. There may be some additional prescribed medications that are not listed, due to the various names.

* Acetaminophen/Tylenol	Ilotycin	Westcort Cream
* Ibuprofen/Advil/Motrin	Intal	
Amoxil/Amoxicillin		Zarontin
Albuterol/Proventil/Ventolin	Keflex	Zithromax
Atarax/Hydroxyzine		Zyrtec
Augmentin	Lasix	
	Lotrimin/Clotrimazole	
Bacitracin		
Bactroban	Macrochantin	
Benadryl		
Bactrim/Septa	Naldecon	
Beclovent/Vanceril	Nystatin Cream	
	Nystatin Oral Suspension	
CTM/Chlortrimeton		
Ceftin	Pedia Care/Kid Care	
Cefzil	Pediazole	
Cortisporin Otic Suspension	Pen VK	
Carbamazopine/Tegretol	Prednisone/Prelone	
	Polytrim	
Depakene/Depokote		
Dexedrine	Reglan	
Dicloxacillin/Dynapen	Ritalin	
Dimetap	Robitussin DM	
Erythromycin	Spectazole Ointment	
Flonase	Sudafed	
Flovent	Sulamyd	
	Suprax	
Gantrisin		
	Theodur	
Happy Hiney Cream	Triaminic	
Hydrocortisone Cream		
	Vanceril	
	Vancenase	

2. The following medications may be used without a prescription: Vaseline, Calamine Lotion, Sunscreen, Chapstick, Desitin and Moisturel/Eucerin.

*** are only to be given in prescription form which states, following immunizations with a beginning time and ending time. No "As Needed" medications will be given with the exception of epi-pens, and asthmatic medications (must be with a prescription).**

HEALTH ASSESSMENT

NAME OF SPONSOR & SPOUSE (Last, first, MI)		TELEPHONE (Home)	TELEPHONE (Duty)
NAME OF MEDICAL TREATMENT FACILITY/PHYSICIAN	ADDRESS (Include ZIP code)		TELEPHONE

CHILD HEALTH INFORMATION

NAME OF CHILD	BIRTHDATE	SEX	HGT	WGT
HAS CHILD BEEN UNDER REGULAR SUPERVISION OF A PHYSICIAN (If yes, explain circumstance(s) and current status)				
YES NO				
HAS CHILD BEEN SCREENED FOR ENROLLMENT IN EXCEPTIONAL FAMILY MEMBER PROGRAM				
YES NO				
COPY OF IMMUNIZATION RECORD SUBMITTED				
YES NO				

DISEASES AND ILLNESSES (CHECK YES OR NO)

CHICKEN POX	<input type="checkbox"/> YES	<input type="checkbox"/> NO	RUBELLA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	TEN-DAY MEASLES	<input type="checkbox"/> YES	<input type="checkbox"/> NO
MUMPS	<input type="checkbox"/> YES	<input type="checkbox"/> NO				POLIOMYELITIS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
SCARLET FEVER	<input type="checkbox"/> YES	<input type="checkbox"/> NO				RHEUMATIC FEVER	<input type="checkbox"/> YES	<input type="checkbox"/> NO

OTHER (List)

CHRONIC ILLNESS AND CONDITIONS (Check Yes or No)

VISION PROBLEMS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	ASTHMA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	DIABETES	<input type="checkbox"/> YES	<input type="checkbox"/> NO
ORTHOPEDIC PROBLEMS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	AUDITORY PROBLEMS	<input type="checkbox"/> YES	<input type="checkbox"/> NO			
SEIZURE DISORDER	<input type="checkbox"/> YES	<input type="checkbox"/> NO						

OTHER (List)

ALLERGIES (List)

COMMENT/INDICATE FREQUENCY

COLDS

EAR ACHES

STOMACH ACHES

HEADACHES

DIARRHEA

CONSTIPATION

BED WETTING

SLEEP DIFFICULTIES

POOR EATING HABITS

TANTRUMS

EXCESSIVE ACTIVITY

DESCRIPTION OF SERIOUS CHRONIC ILLNESS/CONDITIONS

ILLNESS/CONDITIONS	DESCRIPTION

ON-GOING MEDICATION

TYPE	DOSAGE	FREQUENCY	CDP ADMINISTERED

SPECIAL MEDICAL CONSIDERATIONS

DESCRIBE ANY SPECIAL PROGRAM NEEDS, CONSIDERATIONS, OR RESTRICTIONS WHICH THE CHILD REQUIRES, IN ORDER TO PARTICIPATE IN CYTP.

MEDICAL STATEMENT

The above named child has been given a routine medical examination (per age requirements) and is free of infectious or contagious diseases, and is considered to be capable of participating fully in CYTP with the exceptions listed above.

SIGNATURE OF SPONSOR/SPOUSE _____ **DATE** _____

PHYSICIAN'S SIGNATURE & STAMP _____ **DATE** _____



PHOTO RELEASE FORM

I, the undersigned, hereby grant permission to Marine Corps Community Services (MCCS) the right to use any photographs/video/digital images/recordings taken by MCCS of me (or my child) (herein/after referred to altogether as "images"), together with the right of reproduction either wholly or in part, either separately or together, with any retouching, copying, adaptation, alteration or manipulation, and in any medium. I understand that MCCS may choose not to use my images at this time but may do so at its discretion at a later date. I further understand that MCCS may discontinue use of my images without notice. I hereby assign to MCCS, full common and statutory copyright of any images that is may take. I further grant MCCS, the United States Marine Corps, Marine Corps Base Hawaii, their assignees and legal representatives unrestricted use of these images for any lawful purpose including, but not limited to, advertising, promotion, trade, editorial, and/or public display.

I also grant MCCS, the United States Marine Corps, Marine Corps Base Hawaii, their assignees and representatives, or anyone working on their behalf, the right to use my name (or any fictional name) along with these images and/or reproductions in any medium.

I acknowledge that no payment has been made to me for these images. I understand that I do not own the prints, negatives, transparencies, videos or copyright of these images and no further payments are due to me in regards to them. Furthermore, I waive any right to inspect or approve the use of these images in any medium.

I have read this Photo Release form carefully and fully understand its meaning and implications. I agree to indemnify and hold harmless, MCCS, the United States Government and any of its officers or employees from any claims, damages, liabilities, losses, government proceedings, costs and expenses, including attorney's fees and costs of suit arising out of any or all aspects of this agreement.

Name (Please Print)

Signature

Date

If under 18 years of age, consent must be given by parent or guardian.

I hereby certify that I am the parent or legal guardian of the above-named model and I give my consent without reservation to the forgoing on behalf of him, her, or them.

Signature of parent/guardian if under 18 years

Family Child Care

1. This Subsidy program pertains to the Family Child Care (FCC) Providers aboard Marine Corps Base Hawaii and Manana Housing and for:

- Children ages 6 weeks through 5 years old who have active CYTP memberships.
- Full-time care only (30 - 50 hours per week).
- Single/Dual Active Duty Military patrons living or working aboard MCBH, Manana or Camp Smith.
- Active Duty Military w/Civilian Spouse working or going to school full-time (minimum of 30 hours per week of work, or minimum of 9 credit hours of coursework).
- Department of Defense employees
- Other Patrons authorized by the CYTP Administrator

2. Supporting documents necessary to process your application are as follows:

- most recent LES for active duty parent(s)
- most recent pay stub for non-active duty spouse
- proof of school registration for parent(s) who are full-time students
- written "verification of single parent status" and a completed dependency application (NAVMC 10922) from the command is required for all single active duty parents who have never been married along with legal documentation for all separations and/or divorces
- copy of contract for full-time child care with certified Provider

Copies of the above documents must be submitted to the Resource and Referral Office, Bldg 5082. **Sponsor must be present to sign, or spouse must have POA.**

3. To check the status of your subsidy application and for all other questions pertaining to the subsidy program, please **contact Family Child Care at 257-7030.**