Lakeland's Little Learners
240 E Commerce Ct Elkhorn, WI 53121

Dear Preschool Families:

Welcome to Lakeland's Little Learners! Enclosed you will find enrollment forms for your child. These are required by the Department of Children and Families for all children attending group child care centers. Immunization records must be submitted within 30 days of the first day of attendance, and whenever a new immunization is given. Immunization records may be downloaded from the Wisconsin Immunization Registry. Physical examinations must be submitted within the first 90 days of attendance, and every 2 years thereafter.

To submit the enrollment forms, you may email them to info@lakelandslittlelearners.com, fax them to (262)723-8381, or return them to the administrative office. Should you have any questions while completing your enrollment application, please contact the Assistant Director, Debbie Nehs, at 262-723-8391 or dnehs@lakelandslittlelearners.com.

A registration fee of $50 per family is also due at the time of enrollment. Forms of payment are check or cash. If you would like to pay online, click here for instructions on how to use MyProcare.com to make a payment. If you would like to sign up for ACH withdrawls please complete this form and hand it in.

We look forward to meeting you and your child.

Sincerely,
Tami Adams
Administrator

(262)723-8391
(262)723-8381 (fax)
info@lakelandslittlelearners.com
www.lakelandslittlelearners.com

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

http://dcf.wisconsin.gov

CHILD CARE ENROLLMENT

Use of form: Use of this form is mandatory for Family Child Care Centers to comply with DCF 250.04(6)(a)1. Failure to comply may result in issuance of a noncompliance statement. This form may also be used by Group Child Care Centers and Day Camps to comply with DCF 251.04(6)(a)1. and DCF 252.41(4)(a)1. respectively. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian shall fill out the form completely, sign it and submit it to the center prior to the child's first day of attendance. Information on this form shall be kept current. When enrolling a child under two years of age, a completed *Intake for Child Under 2 Years* form must also be on file prior to the child's first day of attendance.

CHILD INFORMATION

Name (Last, First, MI)	Birthdate (mm/dd/yyyy)	First Day of Attendance

PARENT OR GUARDIAN – All parents / guardians are permitted to visit during center hours and are allowed to pick up the child unless access is prohibited or restricted by a court order. Attach court order, if any. If the child resides at multiple locations, the department recommends the provider obtain and attach a schedule.

a. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care

Home Address (Street, City, State, Zip)	Does child reside at this location? ☐ Yes ☐ No	Place of Employment and Work Phone No.

b. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care

Home Address (Street, City, State, Zip)	Does child reside at this location? ☐ Yes ☐ No	Place of Employment and Work Phone No.

AUTHORIZED PERSONS – Persons other than parents / guardians who are authorized to pick up the child or accept the child if dropped off**.** If no one, write "None."

a. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.
b. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.

EMERGENCY CONTACT – The person to be notified in an emergency when parents / guardians cannot be reached.
☐ Yes ☐ No This person is authorized to pick up the child.

Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.

PHYSICIAN OR MEDICAL FACILITY

Name	Address (Street, City, State, Zip Code)	Telephone Number

AUTHORIZATIONS

☐ Yes ☐ No I hereby give my consent for emergency medical care or treatment to be used only if I cannot be reached immediately.
☐ Yes ☐ No I have had an opportunity to review the policies of this child care center and a summary of the Wisconsin Rules for Licensing Child Care Centers.
☐ Yes ☐ No I give permission for my child to participate in ☐ Transported ☐ Walking field trips and other activities during operating hours.
☐ Yes ☐ No I have been informed of the number of pets in the center and their degree of contact with the enrolled children. Note: If pets are added after a child is enrolled, parents shall be notified in writing prior to the pet's addition to the center.

SIGNATURE – Parent or Guardian	Date Signed

HEALTH HISTORY AND EMERGENCY CARE PLAN

Use of form: This form is required for family and group child care centers and day camps to comply with DCF 250.04(6)(a)1. and 250.07(6)(L)5., DCF 251.04(6)(a)6. and 251.07(6)(k)5., and DCF 252.44(6)(g) of the Wisconsin Administrative Codes. Failure to comply may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian should complete this form for placement in the child's file prior to the child's first day of attendance. Information contained on the form shall be shared with any person caring for the child. The department recommends that parents / guardians and center staff periodically review and update the information provided on this form.

CHILD INFORMATION

Name (Last, First, MI)	Address – Home (Street, City, State, Zip Code)	
Telephone Number	Birthdate (mm/dd/yyyy)	Date – First Day of Attendance (mm/dd/yyyy)

PARENT / GUARDIAN INFORMATION Provide information where the parent(s) / guardian(s) may be reached while the child is in care.

Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular
Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular

PHYSICIAN / MEDICAL FACILITY INFORMATION

Name – Physician	Address – Medical Facility	Telephone Number

SUNSCREEN / INSECT REPELLENT AUTHORIZATION If provided by the parent, the sunscreen or insect repellent shall be labeled with the child's name. Per DCF 251.07(6)(f)2., authorizations shall be reviewed every 6 months and updated as necessary. Per DCF 250.07(6)(f)2.a., Authorizations shall be reviewed periodically and updated as necessary.

	Brand Name	Ingredient Strength
☐ Yes ☐ No I authorize the center to apply sunscreen to my child. ☐ Yes ☐ No I authorize the center to allow my child to self-apply sunscreen.		
☐ Yes ☐ No I authorize the center to apply repellent to my child. ☐ Yes ☐ No I authorize the center to allow my child to self-apply repellent.	Brand Name	Ingredient Strength

HEALTH HISTORY AND EMERGENCY CARE PLAN If available, attach any health care plan information from the child's physician, therapist, etc.

1. Check any special medical condition that your child may have.

☐ No specific medical condition
☐ Asthma
☐ Diabetes
☐ Gastrointestinal or feeding concerns including special diet and supplements
☐ Cerebral palsy / motor disorder
☐ Epilepsy / seizure disorder
☐ Any disorder including Cognitively Disabled, LD, ADD, ADHD, or Autism
☐ Other condition(s) requiring special care – Specify.

☐ Milk allergy. If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative.
☐ Food allergies – Specify food(s).

☐ Non-food allergies – Specify.

2. Triggers that may cause problems – Specify.

3. Signs or symptoms to watch for – Specify.

4. Steps the child care provider should follow. If prescription or non-prescription medications are necessary, a copy of the form *Authorization to Administer Medication* should be attached to this form. Note: group child care centers and day camps may use their own form.

5. Identify any child care staff to whom you have given specialized training / instructions to help treat symptoms.
   a.
   b.
   c.

6. When to call parents regarding symptoms or failure to respond to treatment.

7. When to consider that the condition requires emergency medical care or reassessment.

8. Additional information that may be helpful to the child care provider.

SIGNATURE – Parent or Guardian	Date Signed (mm/dd/yyyy)

Review dates: _____ _____ _____ _____ _____

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-04020L (05/2024)

STATE OF WISCONSIN
Wis. Stat. §§ 252.04 and 120.12 (16)

STUDENT IMMUNIZATION RECORD

Instructions to Parent: Complete and return to school within **30 days after admission**. State law requires all public and private school students to present written evidence of immunization against certain diseases **within 30 school days of admission**. The current age/grade specific requirements are available from schools and local health departments. These requirements can only be waived if a properly signed health, religious or personal conviction waiver is filed with the school. The purpose of this form is to measure compliance with the law and will be used for that purpose only. If you have questions regarding immunizations, or how to complete this form, contact your child's school or local health department.

Step 1 **Personal Data** **Please Print**

Student's Name	Birthdate (MM/DD/YYYY)	Gender	School	Grade	School Year

Name of Parent/Guardian/Legal Custodian	Address (Street, City, State, ZIP Code)	Phone Number

Step 2 **Immunization History**

List the **month, day, and year** your child received each of the following immunizations. If you do not have an immunization record for this student, contact your doctor or public health department to obtain it. You may also use the Wisconsin Immunization Registry: https://www.dhfswir.org/PR/clientSearch.do?language=en

Type of Vaccine*	First Dose MM/DD/YYYY	Second Dose MM/DD/YYYY	Third Dose MM/DD/YYYY	Fourth Dose MM/DD/YYYY	Fifth Dose MM/DD/YYYY
DTaP/DTP/DT/Td (Diphtheria, Tetanus, Pertussis)					
Adolescent booster (Check appropriate box) ☐ Tdap ☐ Td					
Polio					
Hepatitis B					
MMR (Measles, Mumps, Rubella)					
Varicella (Chickenpox) Vaccine					
Meningococcal (serogroup ACWY)					

Students with a reliable history of varicella disease are not required to receive the varicella vaccine. Signature from physician, physician assistant, or advanced nurse prescriber required.
☐ I attest that this student has a reliable history of varicella disease,

_____
SIGNATURE – Health Care Provider Date Signed

Has your child had a blood test (titer) that shows immunity (had disease or previous vaccination) to any of the following? Check all that apply.
☐ Varicella ☐ Measles ☐ Mumps ☐ Rubella ☐ Hepatitis B
If **yes**, provide laboratory report(s)

Step 3 **Requirements**

Refer to the age/grade level requirements for the current school year to determine if this student meets the requirements.

Step 4 **Compliance Data**

Student Meets All Requirements
Sign at Step 5 and return this form to school.

Or

Student Does Not Meet All Requirements

Check the appropriate box below, sign at Step 5, and return this form to school. **Please note that incompletely immunized students may be excluded from school if an outbreak of one of these diseases occurs**.

☐ Although my child has **not** received **all** the required doses of vaccine, the **first dose(s)** has/have been received. I understand that the **second dose(s)** must be received by the 90th school day after admission to school this year, and that the **third dose(s)** and **fourth dose(s)** if required must be received by the 30th school day next year. I also understand that it is my responsibility to notify the school in writing each time my child receives a dose of required vaccine.

Note: Failure to stay on schedule may result in exclusion from school, court action and/or forfeiture penalty.

Waivers (List in Step 2 above, the date(s) of any immunizations your child has already received)

☐ **For health reasons** this student should not receive the following immunizations _____

_____ _____
SIGNATURE – Physician Date Signed

☐ **For religious reasons,** I have chosen not to vaccinate this student with the following immunizations (check all that apply)
☐ DTaP/DTP/DT/Td ☐ Tdap, ☐ Polio ☐ Hepatitis B ☐ MMR (Measles, Mumps, Rubella) ☐ Varicella ☐ MenACWY

☐ **For personal conviction reasons,** I have chosen not to vaccinate this student with the following immunizations (check all that apply)
☐ DTaP/DTP/DT/Td ☐ Tdap ☐ Polio ☐ Hepatitis B ☐ MMR (Measles, Mumps, Rubella) ☐ Varicella ☐ MenACWY

Step 5 **Signature**

This form is complete and accurate to the best of my knowledge. Check one: (**I do** ☐ **I do not** ☐) give permission to share my child's current immunization records and as they are updated in the future with the Wisconsin Immunization Registry (WIR). I understand that I may revoke this consent at any time by sending written notification to the school district. Following the date of revocation, the school district will provide no new records or updates to the WIR.

_____ _____
SIGNATURE - Parent/Guardian/Legal Custodian or Adult Student Date Signed

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

Child Health Report – Child Care Centers

Use of form: Use of this form is required unless the health examination report is on an electronic printout from a licensed physician, physician assistant, or other EPSDT provider. Completion of this form meets the requirements of DCF 202.08 (4), DCF 250.04 (6) (a) 4. and DCF 251.04 (6) (a) 8. Failure to comply with these rules may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: Each child under 2 years of age shall have an initial health examination not more than 6 months prior to nor later than 3 months after being admitted to the center and a follow-up health examination at least once every 6 months thereafter. Each child 2 years of age but who is not 5 years of age or older shall have an initial health examination not more than one year prior to nor later than 3 months after being admitted to a center and a follow-up health examination at least once every 2 years thereafter. The parent / guardian shall give this form to the physician, physician assistant, or other EPSDT provider to be completed, signed, and dated. The licensee / operator shall obtain a copy for the child's record. Note: Children are also required to have on file at the child care center documentation of immunizations; it may be helpful if the parent / guardian includes a copy of the child's immunization record when submitting this form to the child care center.

PARENT OR GUARDIAN – This section should be completed by the parent or guardian

Child's Name (Last, First, MI)	Child's Birthdate (mm/dd/yyyy)

Child's Address (Street, City, State, Zip Code)

Parent or Guardian Name (Last, First, MI)

Parent or Guardian Address (Street, City, State, Zip Code)

HEALTH PROFESSIONAL – This section should be completed by the health professional

Instructions for feeding and care of child with special health concerns – Specify: (attach information as necessary).

☐ Yes ☐ No Does the child have a milk allergy? If "Yes," identify the recommended milk substitute.

☐ Yes ☐ No Does this child have any food or non-food allergies? If "Yes," specify and include the treatment plan to be implemented in the event of an allergic reaction.

Date of child's most recent blood lead test: _____ (mm/dd/yyyy).

Note: Children on Medicaid are required to be tested at around ages 12 months and 24 months or once between the ages of 3 and 5 years if no previous test is documented. Lead testing is optional for children who are not on Medicaid.

Immunization(s) not to be administered to child due to medical reason(s) – Specify.

AUTHORIZATION

I certify that I have examined the above child on this date and that he / she is able to participate in child care activities.

Name – MD, PA, or other EPSDT Provider (type or print)	Address (Street, City, State, Zip Code)

SIGNATURE – MD, PA, or other EPSDT Provider	Date of Examination

Lakeland's Little Learners
Elkhorn, Wisconsin

Directory Data Notice

Pursuant to the Family Education Right and Privacy Act and State Statute 118.123 (1)(d), any parent or guardian may inform Lakeland's Little Learners of their desire that directory data, including photographs and videotapes not be used. The most recent form filed for a student shall remain in effect until a new form is filed. You do not need to file a new form each year. Please check one option below. In accordance with state law, you have fourteen days within which to complete this form and return it to school. Failure to complete and return this form to the school within fourteen days will result in Lakeland's Little Learners NOT WITHHOLDING directory data regarding your child.

Directory data includes, but is not limited to: pupil's name, participation in officially recognized activities, photographs (including video tapes and other reproductions), and awards received. Photographs may be used for www.lakelandslittlelearners.com, Facebook, newspaper articles, etc. Directory data shall be considered public information and may be released, unless the parent or guardian informs Lakeland's Little Learners in writing by completing the Directory Data Notice form.

In the course of the school year, students are occasionally videotaped, photographed, or their names are placed in various publications, including postings on internet web pages. The resulting photo, videotape or student's published name may be used in a variety of ways: to promote the school, or specific programs to the community, to instruct students or staff members, or, to orient new parents, staff, and students. The final product could also take a variety of forms: photo displays, slide/Power Point presentations, newspaper articles, pamphlets, video programs, or internet web pages.

On occasion there is media coverage or perchance recordings of school events and activities by outside journalists, students, or other non-district personnel beyond the control of the school. Media coverage may involve, but is not necessarily limited to: voice recordings, still photographs, videotaping or public disclosure of directory data such as the student's name. Even with the consent of the parent/guardian, media coverage of events, activities or issues in school or on school property is allowed only with the permission of the building administrator and only if it does not disrupt or hinder student instruction or other activities.

Please Print

Student's Name _____

□ YES – Please withhold directory data.

□ NO – Please do not withhold directory data.

Parent/Guardian's Name _____

Parent/Guardian's Signature _____

Date Signed _____

Enrollment Agreement

I understand that my child(ren) is enrolled at Lakeland's Little Learners and/or Wrap Around Program. The scheduled date to begin is _____ (date/time). If for any reason I choose not to start on the above date, I must give **two weeks written notice** or I will be charged for two weeks of care for my child(ren). I also agree that if I decide to withdraw my child(ren), I will give two weeks written notice or be billed for the equivalent hours. I also agree to pay promptly, every "Fee Friday" for the upcoming two weeks tuition, based on my contracted hours and any additional requested time. In enrolling, I signify that I have read an agree to the Operating Policies and Fee Schedule, and all fees associated wit that schedule including, but not limited to: Registration, Fees for Service, Early Drop-Off/Late Pick-Up, Late Payment, Drop-In/Schedule Change, Failure to Sign-In or Out on the proper sheet, and a 2 week's Written Notice Before Termination of Fees.

Parent/Guardian's Name

_____ _____ _____
First Name Middle Initial Last Name

Driver's License # _____ Birth Date _____ /_____ / _____

Social Security # _____ - ____ - _____

Parent/Guardian's Name

_____ _____ _____
First Name Middle Initial Last Name

Driver's License # _____ Birth Date _____ /_____ / _____

Social Security # _____ - ____ - _____

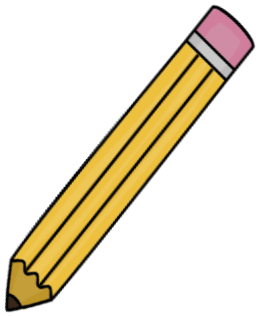
Parent's Receiving Assistance Agreement to Pay Fees

I understand that it is my responsibility to cover all fees charged to me by Lakeland's Little Learners for child care for my child(ren). When there is a written agreement from a government assistance program to cover a portion of my child(ren)'s tuition, I understand that it is **my responsibility to pay my portion on or before the fee Friday for the upcoming two week's that are being billed**. I also understand that if assistance is not received for any reason, I am ultimately responsible for my child(ren)**'s entire bill within two week's of written notice** from Lakeland's Little Learners. Government assistance programs generally do not cover hours scheduled outside the agreed upon schedule or any additional cost such as late fees. I understand that I am responsible for all of these additional costs. If I do not stay current, I understand that my child(ren) will be dropped from the enrollment in the program until the bill is paid in full. If a spot is available for my child(ren) at that point, I may re-enroll if fees are paid for the upcoming two weeks, in full.

Parent Signature _____ Date _____

Child(ren)'s Name(s) _____

Family Questionnaire



Child's name

Date of birth

Nickname

Parent(s) name(s)

Daytime phone number

Evening phone number

Email

The best way to contact me is by:

What are your child's strengths?

Please list any goals that you have for your child this year.

What special interests, sport activities, and/or hobbies does your child have?

Please list any food/product allergies your child has:

Would you like us to incorporate any family traditions/cultures into our program? Would you be willing to come into the classroom to share this information?

Would you be interested in helping with small groups/reading in the classroom?

Is there any additional information you would like to share that would make your child's time here a positive experience?

Please tell us about your family make up. (Who lives in your household? Are there 2 households? Share about your family (travels, pets, other important people...)

Newsletters are emailed. If you do not have an email, please contact your child's teacher if you would like a printed copy. Is a second copy needed for another household?

If English is not your primary language, are you able to read and communicate in English?