Please view the items listed below. They are the items that your child will need on their first day at Small Wonders!

- **Completed enrollment packet.**
- **Copy of their current shot records (due on start date)**
- **Extra clothing (shirt, pants, underwear, socks) *Potty trainers need 4 outfits and extra rubber shoes such as crocs.**
- **Bedding: sheet, blanket, and travel size pillow (if 1 years old and older)**
- **Bedding bag or backpack that fits all of their bedding.**
- **Diapers and wipes, if needed**
- **Labeled re-useable water bottle.**
- **Please make sure all items that are brought into the center are labeled with your child's name**

- **Within 2 weeks of their start date, they will need the form labeled "Child Medical Examination Report" filled out by a doctor**

These supplies will help us keep track of your child's belongings and help keep our center tidy. Please remember to label all items – we appreciate your help!

Registration Form

Please return this form completely filled out and signed, along with your $30.00 non-refundable, non-transferable registration fee.

Name and date of birth of child:

_____

Name of Parent/Guardian(s):
Name: _____Relationship: _____

Cell Phone: _____

Name: _____Relationship: _____

Cell Phone: _____

I, the undersigned, being legally bound, hereby agree to hold harmless Small Wonders Childcare Center LLC, including any agents, employees or representatives and assigns from any and all actions, demands, claims, judgments, and executions which my child may have or acquire and subsequently claim to have against the foregoing for any and all injuries suffered by my child, out of his/her being a participant in the programs-including field trips- at Small Wonders.

Signature: _____ Date: _____

Tuition Payment Agreement

My child _____ (full name) will be attending Small Wonders _____ (days) from _____ to _____ (time of day) starting _____ (date)
My weekly tuition rate is_____

By signing below, I _____(parent's name) agree to all the conditions contained within this agreement and in the handbook I have received. I will pay my tuition on time; tuition includes breakfast, snacks, lunch.

I also agree to pay a yearly supply fee (in advance) or at a rate of $20 per week. I understand that this supply fee is used for children to partially to pay for but not limited to books ,pencils ,crayons, paints, clay, and other art and craft supplies. This fee will also be for garden materials. This supply fee will not be added to your childcare payments at the end of the year for taxes. The yearly supply fee for a full-time student is $100.00. I will pro-rate the fee for part time children.

The yearly supply fee for my child is $_____
I will be paying this in full
I will pay this in 5 payments of $20.00

The agreement remains in affect for one year from the start date above.

Signature: _____ Date: _____

Signature: _____ Date: _____

MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF CHILDHOOD – CHILD CARE COMPLIANCE

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF COMMUNITY FOOD & NUTRITION ASSISTANCE

CHILD CARE ENROLLMENT FORM

FACILITY/PROVIDER NAME	ADMISSION DATE	DISCHARGE DATE
CHILD'S NAME	GENDER	BIRTHDATE
CHILD'S ADDRESS (STREET, CITY, STATE, ZIP CODE)		

IDENTIFYING INFORMATION

PARENT/GUARDIAN NAME	TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS CHILD'S ADDRESS ☐	
EMAIL ADDRESS	
EMPLOYER OR SCHOOL	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER

PARENT/GUARDIAN NAME	TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS CHILD'S ADDRESS ☐	
EMAIL ADDRESS	
EMPLOYER OR SCHOOL	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER

If you or a member of your immediate family ever served in the U.S. Armed Forces, click here for more information about military-related services in Missouri or visit www.dese.mo.gov/veterans-services.

EMERGENCY CONTACT AND PERSONS AUTHORIZED TO TAKE CHILD FROM FACILITY OTHER THAN PARENT (AT LEAST ONE EMERGENCY CONTACT IS REQUIRED)

NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBER(S)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBER(S)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

COMMENTS ON CHILD'S DEVELOPMENT (PERSONAL DEVELOPMENT, BEHAVIOR, PATTERNS, HABITS, & INDIVIDUAL NEEDS)

CACFP REQUIREMENT

RELATED CHILD

☐ Yes ☐ No	CHILD'S RELATION TO CHILD CARE PROVIDER

ETHNIC AND RACE INFORMATION (YOU ARE NOT REQUIRED TO ANSWER THIS SECTION)

Are you of Hispanic or Latino origin? ☐ Yes ☐ No

What is your race? (Select one or more.)	☐ American Indian or Alaskan native	☐ Asian	☐ Black or African American	☐ Native Hawaiian or other Pacific Islander	☐ White

CHILD'S PROJECTED ATTENDANCE SCHEDULE AND ANY VARIATIONS EXPECTED

Will child attend: ☐ Full time ☐ Part time Check what days your child will attend.		When does your child usually arrive each day?	When does your child usually leave each day?	Describe any changes or variations in usual attendance, including shift changes.
Monday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
Tuesday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
Wednesday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
Thursday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
Friday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
Saturday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
Sunday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	

MEALS YOUR CHILD IS USUALLY GIVEN AT THIS FACILITY

☐ Breakfast ☐ Morning snack ☐ Lunch ☐ Afternoon snack ☐ Supper ☐ Evening snack ☐ None

HOLIDAYS YOUR CHILD IS IN CARE AT THIS FACILITY

☐ New Year's Day	☐ Easter	☐ Labor Day
☐ Martin Luther King, Jr.'s Birthday	☐ Truman Day	☐ Columbus Day
☐ Lincoln's Birthday	☐ Memorial Day	☐ Veterans Day
☐ Washington's Birthday	☐ Juneteenth	☐ Thanksgiving Day
	☐ Independence Day	☐ Christmas Day

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I understand that I will be notified at once in the event of an emergency with my child, and I will make arrangements for medical care of my child with the physician or hospital of my choice. If I cannot be reached to make the necessary arrangements, or in a critical emergency requiring medical care, I authorize

_____
(CHILDCARE FACILITY NAME)

to contact the following:

PHYSICIAN OR CLINIC

NAME	TELEPHONE NUMBER

PREFERRED HOSPITAL

NAME	TELEPHONE NUMBER

ACKNOWLEDGMENTS

A	I have received a copy of this facility's policies pertaining to the admission, care, and discharge of children.	PARENT/GUARDIAN INITIALS
B	I have been informed that a copy of the licensing rules for child care home or the licensing rules for group child care homes and centers is available at this facility for review.	PARENT/GUARDIAN INITIALS
C	The provider and I have agreed on a plan for continuing communication regarding my child's development, behavior, and individual needs.	PARENT/GUARDIAN INITIALS
D	When my child is ill, I understand and agree that s/he may not be accepted for care or remain in care.	PARENT/GUARDIAN INITIALS
E	I understand that, before the first day of attendance by my child, I will provide proof of completed age-appropriate immunizations or exemption from immunizations.	PARENT/GUARDIAN INITIALS
F	I ☐ do ☐ do not give permission for field trips/excursions. I understand that I will be notified in advance when they are planned.	PARENT/GUARDIAN INITIALS
G	I ☐ do ☐ do not give permission for the facility to transport my child.	PARENT/GUARDIAN INITIALS
H	I have been informed and have received a copy of the facility's safe sleep policy when enrolling a child less than one (1) year of age.	PARENT/GUARDIAN INITIALS
I	I have been notified that I may request notice at initial enrollment or at any time thereafter whether there are children currently enrolled in or attending the facility for whom an immunization exemption has been filed.	PARENT/GUARDIAN INITIALS

PARENT/GUARDIAN SIGNATURE	DATE

CACFP REQUIREMENT			
	FIRST ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE
	SECOND ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE
	THIRD ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE

USDA Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:**
   U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW Washington,
   D.C. 20250-9410; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   program.intake@usda.gov

This institution is an equal opportunity provider.

MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF CHILDHOOD - CHILD CARE COMPLIANCE

CHILD MEDICAL EXAMINATION REPORT (INFANT/TODDLER/PRE-SCHOOL)

SAVE PRINT RESET

IDENTIFYING INFORMATION

CHILD'S NAME	BIRTHDATE

CURRENT STATE OF HEALTH

Based on my assessment of this child's medical history, current state of health and my physical examination of the child on ____ / ____ / ____, this child can participate in a child care program. This child has no special care needs unless specified below.

(Date of medical examination must be within the last 12 months.)

PHYSICIAN'S INSTRUCTIONS FOR SPECIALIZED CARE

Complete this section only if child requires special care at a child care facility, e.g. special diets, allergies, ear infections, convulsions, diabetes, asthma, behavior problems, hearing or visual impairment, etc. (Attach additional pages as needed.)

SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER THE SUPERVISION OF A PHYSICIAN	DATE

PHYSICIAN'S OR NURSE'S NAME (PLEASE PRINT)

NAME AND ADDRESS OF CLINIC, GROUP, PRACTICE OR OTHER (MAY USE STAMP.)	IF NURSE IS SUPERVISED BY A PHYSICIAN, INDICATE PHYSICIAN'S NAME (PLEASE PRINT.)
	TELEPHONE NUMBER

TO BE FILED IN CHILD'S RECORD AT CHILD CARE FACILITY

Permission to Photograph

I,_____give permission for Small Wonders to photograph my child, _____.

Furthermore, can we use your child photograph...

On Class Dojo? Y/N

On bulletin boards? Y / N

In newsletter? Y / N

In a digital photo frame in the facility? Y / N

Can your child be in group photographs that may be handed out to parents in print or on class dojo?

Yes / No

Can your child be in a group photograph hung throughout the building?

Yes / No

Furthermore, Can we use your child in a video...

On Class Dojo? Y/N

That is displayed to parents on site? Y / N

Can your child be in group video that may be handed out to parents?

Yes / No

I understand that it is my responsibility to update this form in the event that I no longer wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment unless updated.

Signed:_____ Date:_____

Child and Adult Care Food Program
Parent Letter – Non-Pricing Child Care Centers
July 1, 2023 through June 30, 2024

Dear Parent or Legal Guardian:

Our center is currently participating in the Child and Adult Care Food Program. This program reimburses the center for the partial cost of meals provided to children and allows the center to provide nutritious meals without increasing the center's fees to you. If your yearly income is equal to or below the amount listed for your family size on the chart below, your child is eligible for free or reduced-price meals. If the income is higher than the amount listed for your family size, you do not need to complete the income application.

Family Size	Yearly Income	Family Size	Yearly Income
1	$26,973	5	$65,009
2	$36,482	6	$74,518
3	$45,991	7	$84,027
4	$55,500	8	$93,536

For each additional family member, add $9,509

To apply for free or reduced-price meal benefits for your children, you must complete the attached Income Eligibility Form (IEF). Your application for free or reduced-price meal benefits cannot be approved unless the attached application is completed according to the directions provided; however, you are not required to complete the IEF. Notify the center should the household income decrease and/or if the household size increases. A participant may be eligible for free or reduced-price meals. The application is valid until the last day of the month in which the form was approved/dated/signed one year earlier.

Sincerely,

Center Owner/Director

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MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
COMMUNITY FOOD AND NUTRITION ASSISTANCE (CFNA)
CHILD AND ADULT CARE FOOD PROGRAM (CACFP)

INCOME ELIGIBILITY FORM FOR CHILD CARE CENTERS

To apply for free or reduced-price meal eligibility benefits for your child(ren), please fill out this form and return it to the child care center.

PART 1: CHILDREN ENROLLED AT THE CHILD CARE CENTER

Complete information below for children enrolled at the center. If child(ren) are receiving Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamp) or Temporary Assistance (formerly AFDC, now funded by TANF), complete Parts 1, 3, and 4 only. Complete Parts 1, 2, 3, and 4 if you did not provide a SNAP case number or Temporary Assistance case number **for all of the children listed in Part 1.**

NAME (first and last)	FOSTER CHILD	BIRTH DATE	SNAP CASE NUMBER	TEMPORARY ASSISTANCE CASE NUMBER
		/ /		
		/ /		
		/ /		
		/ /		

PART 2: HOUSEHOLD AND INCOME INFORMATION

List all members of the household not including the children listed in Part 1. Indicate source and amount of current monthly gross income for all members of the household before deductions, such as taxes and social security. Where there are wage earners and self-employed adults, the income of the wage earner cannot be offset by the business losses of the self-employed adult. If last month's income does not accurately reflect your circumstances, you may provide a projection of your current annual income. Irregular self-employed income may be averaged over the prior 12 months. Foster children may be eligible regardless of household income. Contact the center for more information.

INCOME BASED ON (CHECK ONE) ☐ YEARLY ☐ MONTHLY ☐ 2 X A MONTH ☐ EVERY 2 WEEKS ☐ WEEKLY

HOUSEHOLD MEMBERS	GROSS WAGES	WELFARE, CHILD SUPPORT, ALIMONY	PENSIONS, RETIREMENT, SOCIAL SECURITY	OTHER

PART 3: RACIAL ETHNIC INFORMATION (You are not required to answer this section)

Are you of Hispanic or Latino origin? ☐ YES ☐ NO

What is your race? (Select one or more)

AMERICAN INDIAN OR ALASKA NATIVE	ASIAN	BLACK OR AFRICAN AMERICAN	NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	WHITE
☐	☐	☐	☐	☐

PART 4: SIGNATURE

I hereby certify that all information provided is correct. I understand that this information is being given in connection with the receipt of federal funds, that institution officials may verify information, and that deliberate misrepresentation may subject me to prosecution under applicable state and federal laws.

SIGNATURE OF ADULT FAMILY MEMBER	SOCIAL SECURITY NUMBER (LAST 4 DIGITS ONLY) XXX-XX-	DATE / /
PRINTED NAME OF ADULT	ADDRESS	PHONE NUMBER ( ) -

Section 9 of the National School Lunch Act requires that, unless your children's SNAP or Temporary Assistance case number is provided, you must include the last four digits of a social security number of the adult household member signing the application or indicate that the household member signing the application does not possess a social security number. Provision of the last four digits of a social security number is not mandatory, but if the last four digits of a social security number are not provided or an indication is not made that the signer has none, the application cannot be approved. The social security number may be used to identify the household member in carrying out efforts to verify the accuracy of information stated on the application. These verification efforts may be carried out through program reviews and investigations, and may include contacting employers to determine income, contacting a SNAP or welfare office to determine current certification for receipt of SNAP or Temporary Assistance benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to provide the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

FOR CENTER USE ONLY

TOTAL HOUSEHOLD SIZE:	INCOME:	INCOME BASED ON (CHECK ONE): YEAR ☐	MONTH ☐	2 X A MONTH ☐	EVERY 2 WEEKS ☐	WEEKLY ☐	SNAP (Food Stamp) ☐	TEMPORARY ASSISTANCE ☐

Eligibility Determination: ☐ Free ☐ Reduced ☐ Paid

SIGNATURE OF CENTER REPRESENTATIVE	DATE

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To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:**
   U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   Program.Intake@usda.gov

This institution is an equal opportunity provider.

12/09/2022

MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF CHILDHOOD – CHILD CARE COMPLIANCE

&

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
CHILD AND ADULT CARE FOOD PROGRAM

INFANT AND TODDLER FEEDING AND CARE PLAN

FOR CHILD CARE FACILITY USE

The formula provided by this child care facility is:	

CHECK A BOX ☐ YES ☐ NO	This child care facility **is participating** in the Child and Adult Care Food Program (CACFP). In order to claim meals and reimbursement, the center must provide infant cereal and other foods when the child is developmentally ready for them.

INSTRUCTIONS (FOR PARENTS)

Please complete for child who is less than 24 months of age. **Update information as needed.** Use a new form or initial/date changes on this form.

CHILD'S NAME	DATE OF BIRTH	DATE ENROLLED

If you or a member of your immediate family ever served in the U.S. Armed Forces, click here for more information about militaryrelated services in Missouri or visit www.dese.mo.gov/veterans-services.

FEEDING INFORMATION

TYPE OF FOOD	FEEDING TIME	KINDS OF FOOD	AMOUNT OF FOOD
Breastmilk			
Formula			
Infant Food			
Table Food			

Who is preparing (mixing) the formula? Check all that apply: ☐ Parent ☐ Caregiver

Does your child have any problems with feedings, such as choking or spitting up?

☐ Yes Explain: _____

☐ No

Does your child use a pacifier? ☐ Yes ☐ No

Note: Pacifiers, if used, cannot be hung around an infant's neck. Pacifier mechanisms or pacifiers that attach to infant clothing cannot be used with sleeping infants.

INFANT FEEDING PREFERENCE (under 12 months)

MARK YOUR PREFERENCE (CHECK ALL THAT APPLY).

☐ I will provide breast milk for my infant.

☐ I will nurse my infant at the center at these times: _____

The facility's formula may be used to supplement feedings if necessary: ☐ Yes ☐ No

If breast milk is unavailable for a feeding, the facility should: _____

☐ I request that the formula provided by the child care facility be served to my infant.

☐ I will provide infant formula for my infant. Name of formula: _____

☐ I request that the child care facility provide solid foods for my infant as s/he is ready for them, and after I have discussed it with child care facility staff. **OR**

☐ I will provide solid foods for my infant.

TODDLER FEEDING PREFERENCE (12 THROUGH 23 MONTHS)

Check all that apply: ☐Spoon ☐Cup ☐Feeds Self ☐Feeding Table or Chair

TYPE OF FOOD	FEEDING TIME	KINDS OF FOOD	AMOUNT OF FOOD
Breastmilk			
Milk			
Table Food			

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ARRANGEMENTS FOR SLEEP – Licensing rules require that infants be placed on their back to sleep.

TIME(S) CHILD USUALLY NAPS	LENGTH OF NAP

ADDITIONAL INSTRUCTIONS RELATED TO SLEEPING:

Note: When, in the opinion of the infant's licensed health care provider, an infant requires alternative sleep positions or special sleeping arrangements that differ from those required by rule, the provider must have on file at the facility written instructions, signed by the infant's licensed health care provider, detailing the alternative sleep positions or special sleeping arrangements for such infant.
The caregiver(s) must put the infant to sleep in accordance with such written instructions.

☐ My child is 12 months or older, and I give my permission for my child to sleep on a cot.

SIGNATURE OF PARENT/LEGAL GUARDIAN	DATE

DIAPERING INSTRUCTIONS

LIST ANY LOTIONS AND/OR OINTMENTS, ETC. THAT YOU HAVE PROVIDED AND GIVE PERMISSION FOR CAREGIVERS TO USE ON YOUR CHILD:

FOR ☐ WET ☐ BOWEL MOVEMENT ☐ RASH ☐ OTHER

☐ I do not want caregivers to use any lotions, powders, ointments, or similar items on my child.

I WILL FURNISH THE FOLLOWING BABY SUPPLIES FOR MY CHILD; CLEARLY LABELED WITH MY CHILD'S NAME:

SPECIAL INSTRUCTIONS FOR CARE (E.G., RESTRICTIONS, ALLERGIES, ETC.):

SIGNATURE OF PARENT/LEGAL GUARDIAN	DATE

Infant Car seat Agreement

I, _____ , acknowledge that Small Wonders
Parent's Name
Childcare is not responsible for buckling my child's car seat and I am responsible for double checking that they are buckled properly.

Sign:_____ Date:_____

INFANT SAFE SLEEP POLICY

Small Wonders Child Care Center

Purpose: The purpose of the Safe Sleep Policy is to maintain a safe sleep environment that reduces the risk of sudden infant death syndrome (SIDS) and sudden unexpected infant deaths (SUIDS) in childcare less than one year of age. Missouri law (S 210.223.1,RSMo.) requires all licensed child care facilities that provide care for children less than one year of age to implement and maintain a written safe sleep policy in accordance with the most recent safe sleep recommendations of the American Academy of Pediatrics (AAP). Missouri child care licensing rules require licensed child care facilities to provide parent(s) and/or guardian(s) who have infants in care be provided a copy of the facilities safe sleep policy.

Sudden Infant Death Syndrome is the sudden death of an infant less than one year of age that cannot be explained after a thorough investigation has been conducted, including a complete autopsy, an examination of the death scene, and review of the clinical history.

Sudden Unexpected Infant Death Syndrome is the sudden and unexpected death of an infant less than one year of age in which the manner and cause of death are not immediately obvious prior to investigation. Causes of Sudden Unexpected Infant Death include, but are not limited to, metabolic disorders, hypothermia or hyperthermia, neglect or homicide, poisoning, and accidental suffocation.

Child care providers can maintain safer sleep environments for infants that help lower the chances of SIDS. Our goal is to take proactive steps to reduce the risk of SIDS in child care and to work with parents to keep infants safer while they sleep. To do so, this facility will practice the following safe sleep policy:

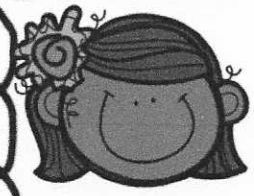
SAFE SLEEP PRACTICES

1. Infants will always be placed on their backs to sleep. When, in the opinion of the infants licensed health care provider, an infant alternative sleep positions or special sleeping arrangements, the provider must have on file at the facility written instructions, signed by the infant's licensed health care provider, detailing the alternative sleep positions or special sleeping arrangements. Caregivers will put the infant to sleep as specified in the written instructions,
2. When infants can easily turn from their stomachs to their backs and from their backs to their stomachs, they shall be initially place on their backs, but shall be allowed to adopt whatever positions they prefer for sleep. The AAP recommends that infants are placed on their back to sleep, but when infants can easily turn over from their back to stomach they may adopt whatever sleep position they prefer for sleep. We will follow the recommendations of the AAP.

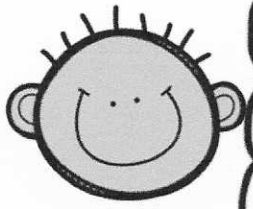
3. Sleeping infants shall have a supervised nap period. The caregiver shall check on the infant frequently during napping or sleeping and shall remain in close proximity to the infant in order to hear and see them if they have difficulty during napping or when they awaken.
4. Steps will be taken to keep infants from overheating by regulating the room temperature, avoiding excess bedding, and not over-dressing or over-wrapping the infant. Infants should be dressed appropriately for the environment, with no more than (1) layer more than an adult would wear to be comfortable in that environment.
5. All caregivers will receive an in-person or online training on infant safe sleep based on AAP safe sleep recommendations. This training must be completed within 30 days of employment or volunteering and will be completed every three years.

SAFE SLEEP ENVIRONMENT

1. Room temperature will be kept at no less than 68°F and no more than 85°F when measured two feet from the floor. Infants are supervised to ensure they are not overheated or chilled.
2. Lighting in the room shall always be bright enough so children can be seen breathing while in their cribs.
3. Infants' heads and face will not be covered during sleep. Infants' cribs will not have blankets or bedding hanging on the sides or top of the crib. **We may use sleep clothing (i.e. sleep sack, sleepers) that is designed to keep an infant warm without the possible hazard of covering the head or face during sleep/nap time.**
4. Toys and stuffed animals will not be placed in cribs. **When indicated on the Infant and Toddler Feeding and Care Plan or with written consent, pacifiers will be allowed in infants' cribs while they sleep. The pacifier cannot have cords or attaching mechanisms.**
5. No blankets, loose bedding, comforters, pillows, bumper pads, or any object that can increase the risk of entrapment, suffocation or strangulation will be used in cribs, playpens or other sleeping equipment.
6. Only an individually assigned safety approved crib, portable crib or playpen with a firm mattress and a tight fitting sheet will be used for infant napping or sleeping.
7. Only one infant may occupy a crib or playpen at one time.
8. Sitting devices such as car seats, strollers, swings, infant carriers, bouncy seats, and other sitting devices will not be used for sleep/nap time. Infants who fall asleep anywhere other than a crib, portable crib, or playpen must be placed in a crib for the remainder of their naptime.
9. No person shall smoke or otherwise use tobacco products in any area of the child care facility during the period of time when children cared for under the license are present.
10. Home monitors or commercial devices marketed to reduce the risk of SIDS shall not be used in place of supervision while children are napping and sleeping. Sound machines will not be used also.
11. All parents/guardians of infants shall be informed and given a copy of the facilities written Safe Sleep Policy at enrollment.
12. To promote healthy development, infants who are awake will be given supervised "tummy time" for exercise and for play.



GETTING TO KNOW YOUR CHILD!



No one knows your child better than you! Please take a few minutes to fill out this questionnaire about your little one, so I may have a better understanding of how I can help!

Student Name: _____

Parent(s) Name: _____

Sibling(s) Names and Ages: _____

Best Number to Reach You: _____

Email Address: _____

Best Time to Reach You: morning____afternoon_____evening_____

Best Way to Reach You: phone_____email_____note_____

How would you describe your child? (Check all that apply)

Outgoing __ Shy__ Talkative__ Quiet__ Leader__ Follower__
Dramatic__ Calm__ Organized__ Messy__ Obedient__
Challenging__ Curious__ Humorous__ Timid__ Responsible__
Respectful__ Easily Distracted __ Artistic __ Creative __
Enjoys School __ **Nervous** __ **Other**_____ __ **Other**_____ __

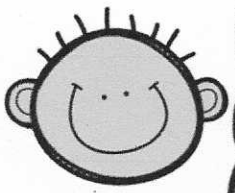
I think my child is doing well with:

Math ___ Penmanship ___ Writing ___ Letter Recognition & Sounds ___
Reading ___ Behavior ___ Following Rules & Directions ___ Social Skills ___
Making Friends ___ Other _____

I think my child is struggling with:

Math ___ Penmanship ___ Writing ___ Letter Recognition & Sounds ___
Reading ___ Behavior ___ Following Rules & Directions ___ Social Skills ___
Making Friends ___ Other _____

GETTING TO KNOW YOUR CHILD!



Please take a few minutes to jot down some brief details about your child. No one can describe your little one better than you!

What are your child's special interests? Does he/she play sports? Outside activities? What does he/she love to do? Favorite things?

Please describe your child in your own words. Is there anything you would like me to know? What makes your child unique?

Are there any special circumstances you would like me to know about your child? (divorce/custody, death in the family, sibling issues, counseling, etc.)