**Seeds of Jesus Daycare, LLC**
**12 Mary Ella Drive Suite F Wilmington, DE 19805**
**(302)993-1234**
**(302)668-1143 Fax**
**info@seesdofjesusdc.com**

**Date:** _____

**Dear** _____,

**Welcome to Seeds of Jesus Daycare. LLC family. We are pleased to confirm your Seeds of Jesus Daycare, LLC registration approval.**

**Your child(ren) first date will be**

_____.

**To make this enrollment official you must complete and return all registration documents before** _____.

**We have an outstanding waiting list, for this reason if the documentation is not on before the agreed date, your child will be taking out the enrollment list without any notice. After completing all documentation, you must schedule an appointment with the administration office. The registration and orientation take about an hour. For any question, please contact the administration office at (302)993-1234**

**Sincerely,**

**Seeds of Jesus Daycare, LLC**

**Administration Office**

# POC AGREEMENT

**POC Parent/Guardian Child Care Agreement**

**The following agreement is made between:**

1. _____ _____ _____
Mother/Legal Guardian Home Phone Work Phone

_____
Home Address

_____
Employer's Name and Address

**And**

2. _____ _____ _____
Father/Legal Guardian Home Phone Work Phone

_____
Home Address

_____
Employer's Name and Address

**And**

3. **Seeds of Jesus Day Care Center** **302-993-1234**

**12 Mary Ella Drive Suite F Wilmington, DE 19805**

**For the care of:**

4. _____ _____
Child's name/Date of Birth Child's name/Date of Birth

_____ _____
Child's name/Date of Birth Child's name/Date of Birth

# POC AGREEMENT

## What is Purchase of Care PLUS?

Parents or guardian who may qualify for the social services childcare tuition assistance, will have to meet the payment fee established for the child age group in our institution. Tuition fee and calculation will be broken down in the POC Plus Worksheet accordingly.

**Overtimes Rates:**
Childcare business days and hours are Monday to Friday from 6:30AM to 5:30PM.

- Parent/ childcare service agreement cannot exceed 10 hours.

| | |
|---|---|
| Drop-off before | AM |
| Pick-up before | PM |

- If the parent/legal guardian exceed the 10 hours in childcare will be charge with $10 per every five (5) minutes or portion thereof. We have the right to dismiss your child from school if you fail to pay your tuition fee or late fees.

Children are allowed no more than 5 absent days each month. Seeds of Jesus Daycare reserves the right to dismiss the child from the program due to excessive absences. In that case, the parents will have a ONE-week period to find another childcare. If the child(ren) has been sick and stayed at home, the parent or guardian must present a doctor's specifying the number of days the child must be keep in home and the reason.

**Holidays and In-Service Days**

1. The following are paid holidays when they fall on a day regularly scheduled for care:

| | |
|---|---|
| January | New Year/Martin Luther King |
| March | Good Friday |
| May | Memorial Day |
| July | Independence Day |
| September | Labor Day |
| November | Thanksgiving Day/Black Friday |
| December | Christmas |

# POC AGREEMENT

| | |
|---|---|
| Staff Trainings / In-Service Day | Will be announced in advance. |

**Seeds of Jesus Daycare, LLC Schedule**
Our program hours are from 6:30 A.M. to 5:30 P.M. However, all students must be at the center before 9 A.M. If you cannot bring your child to school by 9 A.M. you must contact the school using the Procare engage application or call at (302)993-1234.

**Charges**
Parents or guardians are responsible for paying field trips, returned checks, and late fees.

**Termination Procedure:**

- Parent or guardian must give a one week writing notice to withdraw the child.
- Co-pay must be paid in full.
- If co-pay is late, we have the right to dismiss the child from school.
- Seeds of Jesus Daycare, LLC reserves the right to terminate this contract with one week notice if the parent/guardian fails to comply with policies and procedures stated our parent handbook.
- In the circumstances that parent/guardian no longer qualified for the Purchase of Care subside, you will have to sign a new tuition contract as a private payment client.

# POC AGREEMENT

**Signatures:**

By signing this contract, parent(s)/guardian(s) agree to abide by the written policies of the provider. **Seeds of Jesus** may amend the policies by giving the parent(s)/guardian(s) a copy of the new or changed policies at least one (1) week(s) before they go into effect.

**Seeds of Jesus Daycare, LLC By:** _____ **Date**_____

**Mother/Legal Guardian** _____ **Date**_____

**Father/Legal Guardian** _____**Date**_____

**Co-signer** _____**Date**_____

**If the parent or legal guardian is under age 18, a co-signer must sign this agreement and act as a guarantor to the contract and agree to be bound by all terms.**

*DELAWARE HEALTH AND SOCIAL SERVICES*

**DIVISION OF SOCIAL SERVICES**

# *Purchase of Care (POC) Plus Worksheet**

**Total to Collect from Parent:**

**Parent Weekly Copayment Fee (Line 4)** _____

**POC+ Weekly Fee from Parent (Line 8)** _____

**The Total Weekly POC Plus fee is (Line 4 + Line 8)** _____

**The total weekly amount I owe this provider is**_____**for this child.**
(My DSS POC co-pay and POC Plus Fees)

***Parent Signature:*** _____ ***Date:*** _____

***Site Signature:*** _____ ***Date:***_____

# Child's File Checklist

All items are to be completed before the child attends the center, except as noted:

| Child file requirements: | Date completed or documented: |
|---|---|
| **Name:** | |
| **Date of birth:** **Date of enrollment:** | |
| ☐ Parents'/Guardians' names | |
| ☐ Parents'/Guardians' place(s) and hours of employment and work phone number(s), if applicable | |
| ☐ Parents'/Guardians' home phone number(s) | |
| ☐ Parents'/Guardians' cell phone number(s) | |
| ☐ Names and phone numbers of two people authorized to pick up the child | |
| ☐ Name and phone number of child's doctor | |
| ☐ Court orders on custody and visitation arrangements, if applicable | |
| ☐ Hours/days child is to attend: | |
| ☐ Parents' Right to Know acknowledgement | |
| ☐ Permission for emergency medical treatment | |
| ☐ Physical (within 30 days of enrollment) | |
| Documents required, if applicable | |
| ☐ Infant/Toddler development plan (within 45 days of enrollment) | |
| ☐ Preschool-age child's annual progress on developmental and educational goals | |
| ☐ Screen time permission (TV, DVD, computer, tablet, etc.) | |
| ☐ Written infant feeding schedule | |
| ☐ Permission to sleep on a mat (if 12-18 months old and walking) | |
| ☐ IEP, IFSP, or Section 504 plan | |
| ☐ Information on allergies | |
| ☐ Existing illnesses or injuries, previous serious illnesses or injuries | |
| ☐ Prescription and non-prescription medication | |
| ☐ Swimming permission | |
| ☐ Transportation permission | |
| ☐ Child accident/injury reports | |
| ☐ Administration of medication records | |
| ☐ Statement that parent is providing meals and/or snacks | |

# Child Information Card
## State of Delaware
## Department of Services for Children, Youth, and Their Families

| Child's Information | | | |
|---|---|---|---|
| Child's name: | Date of birth: | Date of enrollment: | Date of discharge: |
| Child's address: | | Hours and days child is scheduled to attend: | |
| **Parent/Guardian Information (1)** Emergency Contact/Authorized to Pick-up Child | | **Parent/Guardian Information (2)** Emergency Contact/Authorized to Pick-up Child | |
| Name: | | Name: | |
| Address, if different from child's: | | Address, if different from child's: | |
| Home phone: | Cell phone: | Home phone: | Cell phone: |
| Work phone: | Hours of employment: | Work phone: | Hours of employment: |
| Employer name and address: | | Employer name and address: | |

| Additional Emergency Contacts and People Authorized to Pick-up Child | | |
|---|---|---|
| Name: | Address: | Phone: |
| Name: | Address: | Phone: |
| Name: | Address: | Phone: |

☐ Emergency Medical Care

I, _____, the parent (or legal guardian) of _____, who is my minor child, hereby authorize emergency medical treatment for my child in the event I cannot be contacted to give permission to treat. I understand I will be financially responsible for the cost of such treatment.

☐ Transportation

I, _____, the parent (or legal guardian) of _____, who is my minor child, hereby give permission for my child to be transported by the center.

_____ _____

Signature of parent/guardian Date

| Medical Information | |
|---|---|
| Name of child's physician: | Office phone: |
| Special medical information, medications, allergies, diet: | Health insurance identification information: |

*The above information is necessary for your child's protection and this facility is required to have it. Keep this information current.*

# Permission to Photograph

I,

_____

Give permission for (Parent or Guardian's name)

_____

(Name of childcare provider or facility)

To photograph my child,

_____

(Child's name)

For the following purposes:

| Type of Use: | (Please check one) | |
|---|---|---|
| | Grant Permission | Decline Permission |
| **Still Photographs:** | | |
| Display on daycare bulletin boards, show to current and prospective clients | | |
| Display still photos on daycare website | | |
| **Videos:** | | |
| Show to current clients | | |
| | | |

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.

Signed:

_____

(Parent or Guardian signature, and date)

CENTER CHILD ACKNOWLEDGMENT AND PERMISSION

**PARENTS RIGHT TO KNOW NOTICE**

UNDER THE DELAWARE CODE, YOU ARE ENTITLED TO INSPECT THE ACTIVE RECORD AND COMPLAINT FILES OF ANY LICENSED CHILD CARE FACILITY. TO REVIEW A CHILD CARE FACILITY RECORD CONTACT: the administrative specialist, OFFICE OF CHILD CARE LICENSING, 3411 SILVERSIDE ROAD, CONCORD PLAZA | HAGLEY BUILDING, WILMINGTON, DELAWARE 19810, phone (302) 892-5800.

You may also view substantiated complaints and compliance review histories by visiting the Office of Child Care Licensing's child care search at https://kids.delaware.gov/occl/search-for-child-care.shtml

Parent/Guardian Signature Date

**SCREEN TIME PERMISSION**

Children over the age of two may have an educational video, movie, or game incorporated into their curriculum. These may be viewed on a television, computer, tablet, or gaming device. These will be age-appropriate and limited to one hour per day unless a special occasion or activity occurs. Children will be closely supervised while using the internet.

Parent/Guardian Signature Date

**PARENT PERMISSION TO SLEEP ON A MAT**

Children, between the ages of 12 and 18 months will be transitioned from sleeping in a crib to a cot, mat, or bed when they are able to walk.

Parent/Guardian Signature

# MEDICATION ADMINISTRATION RECORD (MAR)
## (FOR MEDICATIONS GIVEN ROUTINELY OR FOR A LIMITED TIME)

CHILD'S NAME: _____ DOB: _____ ALLERGIES: _____

PARENT'S/GUARDIAN'S NAME: _____ DOCTOR: _____ TELEPHONE: _____

MONTH AND YEAR: _____

| MEDICATION INFO | TIME | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MEDICATION NAME: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DOSAGE: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ROUTE: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| REASON: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| START DATE: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| END DATE: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SPECIAL INSTRUCTIONS: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

I, _____, the parent/guardian of the above listed child, give permission for the above medication to be administered.

_____ _____

Signature Date

| DATE: | TIME: | COMMENTS/MEDICATION ERRORS/ADVERSE EFFECTS: | DATE AND TIME PARENT/GUARDIAN INFORMED OF ERRORS OR ADVERSE EFFECTS |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

| NAME OF PERSON ADMINISTERING | INITIALS |
|---|---|
| | |
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| | |
| | |

**ROUTE OF ADMINISTRATION; SELECT ONE**

ORAL *(BY MOUTH)*
EYE DROPS *(OPTIC)*
NOSE DROPS/SPRAY *(NASAL)*
EAR DROPS *(OTIC)*
TOPICAL *(ON SKIN)*
INHALATION *(NEBULIZER)*
INJECTON (*SYRINGE, PEN, OR ELECTRONIC INFUSION DEVICE* )
RECTAL

# MEDICATION ADMINISTRATION RECORD (MAR)
## (FOR MEDICATIONS GIVEN AS NEEDED OR FOR EMERGENCY USE)

CHILD'S NAME: _____ DOB: _____ ALLERGIES: _____

PARENT'S/GUARDIAN'S NAME: _____ DOCTOR: _____ TELEPHONE: _____

| **MEDICATION INFO** |
|---|
| **MEDICATION NAME:** |
| **DOSAGE:** |
| **ROUTE:** |
| **REASON:** |
| **START DATE:** |
| **SPECIAL INSTRUCTIONS:** |

| **TIME:** | **DATE:** | **NAME OF PERSON ADMINISTERING:** |
|---|---|---|
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**ROUTE OF ADMINISTRATION; SELECT ONE**

ORAL *(BY MOUTH)*
EYE DROPS *(OPTIC)*
NOSE DROPS/SPRAY *(NASAL)*
EAR DROPS *(OTIC)*
TOPICAL *(ON SKIN)*
INHALATION *(NEBULIZER)*
INJECTION *(SYRINGE, PEN, OR ELECTRONIC INFUSION DEVICE)*
RECTAL

***Dates and times of sunscreen, diaper cream, and insect repellent applications do not need to be documented. However, all other information and parent permission for these medications are required on the MAR.***

I, _____, the parent/guardian of the above listed child, give permission for the above medication to be administered.

_____ _____
Signature Date

| **DATE:** | **TIME:** | **COMMENTS/MEDICATION ERRORS/ADVERSE EFFECTS:** | **DATE AND TIME PARENT/GUARDIAN INFORMED OF ERRORS OR ADVERSE EFFECTS** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

NAME_____

BIRTHDATE_____

STATE OF DELAWARE
DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH AND THEIR FAMILIES
OFFICE OF CHILD CARE LICENSING

# CHILD HEALTH APPRAISAL

Family Child Care
Large Family Child Care Home
Day Care Center

## SECTION A: TO BE COMPLETED BY PARENT BEFORE PHYSICAL EXAMINATION

CHECK IF CHILD HAS PROBLEMS WITH ANY OF THE FOLLOWING: GIVE ADDITIONAL COMMENTS BELOW

- ☐ Allergies (food, medicine, bee sting etc.)
- ☐ Constipation/Diarrhea
- ☐ Frequent Colds
- ☐ Hearing Difficulty
- ☐ Seizures
- ☐ Fainting
- ☐ Speech Difficulty
- ☐ Vision Difficulty
- ☐ Physical Handicap
- ☐ Behavior Problem
- ☐ Asthma

Other_____

Comments:_____

ADDITIONAL INFORMATION ABOUT YOUR CHILD (include serious illness, accidents, operations, medications, etc. with dates):

Parent/Guardian's Signature_____ Date_____

## SECTION B: TO BE COMPLETED BY EXAMINING PHYSICIAN/PEDIATRIC NURSE PRACTITIONER

CODE: X - Within Normal Limits O - See Remarks Below

| | | | | |
|---|---|---|---|---|
| _____ Scalp, Skin | _____ Heart | _____ Vision | _____ Ear, Nose | _____ Lungs |
| _____ Hearing | _____ Throat | _____ Abdomen | _____ Blood Pressure | _____ Eyes |
| _____ Genitalia | _____ Teeth | _____ Extremities | _____ Neck, Glands | _____ Nervous System |
| _____ Height | _____ Weight | | | |

REMARKS AND RECOMMENDATIONS: _____

IS CHILD PROGRESSING NORMALLY FOR AGE GROUP? _____

| | | | | |
|---|---|---|---|---|
| DTP/Hib 1 / / | DTP/Hib 2 / / | DTP/Hib 3 / / | DTP/ Hib 4 / / | DTaP/Hib 4 / / |
| DTP/DTaP 1 / DT / / | DTP/DTaP 2 / DT / / | DTP/DTaP 3 / DT / / | DTP/DTaP 4 / DT / / | DTP/DTaP 5 / DT / / |
| Td 1 / / | Td 2 / / | Td 3 / / | / / | / / |
| OPV/IPV 1 / / | OPV/IPV 2 / / | OPV/IPV 3 / / | OPV/IPV 4 / / | TB Screening 12 mo / / |
| MMR 1 / / | MMR 2 / / | HepB 1 / / | HepB 2 / / | HepB 3 / / |
| Hib 1 / / | Hib 2 / / | Hib 3 / / | Hib 4 / / | Hep B/Hib 1 / / |
| Hep B/Hib 2 / / | Hep B/Hib 3 / / | Varicella 1 / / | Varicella 2 / / | Influenza 1 / / |
| Influenza 2 / / | Pneumococcal Polysaccharide1 / / | Pneumococcal Polysaccharide 2 / / | Pneumococcal Conjugate 1 / / | Pneumococcal Conjugate 2 / / |
| Pneumococcal Conjugate 3 / / | Pneumococcal Conjugate 4 / / | Hep A 1 / / | Hep A 2 / / | Lyme Vax 1 / / |
| Lyme Vax 2 / / | Lyme Vax 3 / / | Other: / / | Lead Screening 12 mo / / | |

Examiner's Signature_____ ☐ M.D. ☐ P.N.P. Date:_____

Printed Name:_____ Telephone:_____

# Health History

1. Child's name _____ BirthDate _____
2. Last Physical Examination _____

3. Illnesses: (*please circle*)

Does your child have any problems with any of these?

Constipation
Convulsions
Diarrhea
Fainting Spells
Frequent Colds
Frequent Ear Infections
Frequent Sore Throats
Lice
Ringworm
Skin Rash
Soiling
Stomach Upsets
Urinary Problem
Worms

Has your child had any of these diseases?

Asthma
Bronchitis
Chicken Pox
Diabetes
Heart Disease
Hepatitis
Impetigo
Measles
Mumps
German Measles
Polio
Scarlet Fever
Tuberculosis
Whooping Cough

3. Other ILLNESSES? (*besides above*) _____
4. Has your child been HOSPITALIZED? (*explain*) _____
5. Has your child had INJURIES with fractures or loss of consciousness? (*explain*)
   _____
   _____
6. Last VISION Test Date _____ Last HEARING Test Date _____
7. Last DENTIST Visit Date _____
8. Any other members of your family with SERIOUS ILLNESS recently? _____
   _____
9. Any other members of your family history of: ASTHMA ____ DIABETES ____ EPILEPSY____

# About Your Child

1. What FOODS does your child especially like? _____

2. Especially DISLIKE? _____

3. Favorite toys, games, activities? _____

4. Is your child TOILET TRAINED? _____ What words does your child use for toilet? _____

5. How does your child express ANGER or frustration? _____

6. Does your child have any special FEARS? _____

Explain _____

7. When your child is upset, what helps to COMFORT him/her? _____

8. How do you DISCIPLINE your child? _____

9. Has your child been taking an afternoon NAP? _____ If so, how long? _____

If not, why? _____

10 . Special toy or blanket for NAP? _____

11. Special FAMILY situations? ( *such as custody specifications, problems arising from situations, etc.*) _____

_____

12. Anticipated ADJUSTMENT problems? _____

_____

13. Any disorders/developmental (slow, advanced) diagnosed or suspected? _____

_____

14. Previous childcare child has attended: _____

15. Any problems at previous daycares? _____

16. EXPECTATIONS of Day Care Home _____

_____

17. Other COMMENTS? _____

_____

# Seeds of Jesus Daycare, LLC
# Sick Child Policy

A. HEALTH REQUIREMENTS. All children must be up to date on all shots: unless there is a medical reason (documentation is required). All children also must have had a well child check within six months before enrolling into the daycare.

If a child is ill in any way, we will not, under any circumstances, be able to keep them. This rule is enforced not only for the protection of the staff but the children as well. It is the policy to notify parents immediately when a child becomes ill and to make arrangements for the child to be picked up. We will need for the child to be picked up within one hour of the phone call. In the event of head lice, children must be treated and nit free BEFORE returning. If a case is found in the daycare, a notice will be given to all parents and all heads will be checked.

B. SICK/EXCLUSION POLICY. For the health of the children and their families, and the daycare staff members, this policy will be strictly enforced.

If your child become ill during his/her time in the daycare, you will be notified and determination the best way to handle the situation, which may include your child being sent home. It is in everyone's best interest that a sick child stays home. If a child has any of the symptoms listed below, they will not be permitted to attend care until 24 hours AFTER the last incidence of fever, vomiting, severe diarrhea, or until 24 full hours after medical treatment has begun as prescribed by a physician. The symptoms include:

- Fever of 100 or higher
- Skin rash other than diaper rash or prickly heat - child will not be allowed to come for care until a medical exam (written documentation from physician required) has indicated it is not a communicable disease.
- Diarrhea - increased number and water content of stools that cannot be contained within the diaper or underwear.
- Vomiting two or more times in the same day
- Any parasitic infestation (lice, scabies, etc.)
- Pink eye
- Chicken pox - until all blisters have dried and formed scabs, usually about 6 days after the onset of the rash.
- Any other communicable disease (tuberculosis, etc.)

! *NOTE*: A good rule of thumb to follow is if you have to give your child any medication to relieve any of the above-mentioned symptoms before you bring them, PLEASE KEEP THEM HOME! Further, there are times when a child is not that ill, but is uncomfortable and really needs the comfort of home. For example, until 24 hours after the first dose of antibiotic to treat ear infection; or when irritability strong cough, and a thick nasal discharge are present during the tail end of an upper respiratory infection. At those times, it is strongly urge to keep your child at home. It is important to have consideration to the health of the other children, and staff. Seeds of Jesus Daycare's health consultant, DuPont Pediatrics, advised us that the first two days of illness are generally the most contagious time. Although winter runny noses are somewhat unavoidable, please use your best judgment, and call if you are unsure. **If you repeatedly attempt to bring an obviously ill child, this may be grounds for termination of childcare services.**

Children suspected of having a communicable disease will not be able to come to the daycare. In the event a communicable disease develops during the day, the child's parents will be contacted immediately for the child to be picked up.

# Seeds of Jesus Daycare, LLC
## Sick Child Policy

When your child is sent home from care for any one of the **Following** Reasons listed **Below**, you will receive a doctor's referral. This form must be completed, signed by the physician and stamped with the physician's license number before your child may return to care. A note on a physician's prescription letterhead is also acceptable.

Communicable Diseases:

1) Chicken Pox
2) Pink Eye
3) Any parasitic infestation (lice, scabies, etc.)

Although the staff is trained in infant and child CPR, basic first aid, and recognition of communicable childhood diseases, **we do not pretend to be a doctor, and will not under any circumstances provide any medications. You must provide any and all medications for your child.** We will not send a child home with a common cold, unless accompanied by a fever or other severe symptoms. However, many times when young children are ill, they may not exhibit "classic" signs of the illness (fever, vomiting, etc.) but will be excessively fussy and/or require constant cuddling and attention.

**While we believe in providing as much cuddling as desired, if a child is ill and requires my undivided attention this distracts from my ability to provide quality care to all the children in the group.** Therefore, if your child reaches a point when he/she requires constant attention, will not play, cries continuously, whines and wants to be held constantly, etc., then your child will need to stay home.

You should expect that any time a new child is introduced to the group, colds and other minor illnesses are likely to occur until everyone's immune systems have adjusted to the new exposures. **Also, advise us whenever a member of your family has an illness so that we can be alert to the possibility of symptoms developing in the child or group.**

Children may return to care only at such time as they will not longer endanger the health of other children. They must be able to participate in daily activities, and the following conditions must have been met.

- Absence of fever for 24 hours
- Nausea, vomiting or diarrhea has subsided for 24 hours
- Children must have been on antibiotics for a period of 24 hours
- Physician has approved readmission into care
- Chicken pox lesions are completely crusted over
- Scabies are under treatment
- Lice are under treatment, and no nits are present on hair
- Pinworm treatment has occurred 24 hours before readmission
- Lesions from impetigo are no longer weeping
- Conjunctivitis has diminished and been treated to the point that the eyes are no longer discharging
- The child has completed the contagious stage of the illness.

**Please note that no child will be readmitted after a communicable disease without a statement from a medical facility or physician.**

**Seeds of Jesus Daycare, LLC**
**Sick Child Policy**

C. MEDICATIONS. If your child is taking medication, please be sure to sign a release to administer medication form. We CANNOT administer medication to ANY child without this release being signed. All medication must remain in the original container and be properly labeled with the child's full name, date prescription was filled, medication expiration date, and legible instructions for administration. Please do not leave the medication in the diaper bag.
For non-prescription medication, the following can be given with permission from the parents, only at the dose & for the duration & method of administration specified on the manufacturer's label for the age and/or weight of the child needing the medication.

- Antihistamines
- Tylenol
- Decongestants
- Anti-itching ointments/lotions
- Diaper ointments/lotions
- Non-narcotic cough suppressants

Non-prescription oral medications may not be administered for more than five consecutive days. All non-prescription topical ointments, creams, or lotions may not be administered for more than seven consecutive days when used for skin irritations.
All administrations of medications will be documented.

Parents Signature: _____ Date: _____

Parents Signature: _____ Date: _____

Providers Signature: _____ Date: _____

Revised on January 2019

**Acknowledgements of Policies**

I, _____ and _____
Have read and understand all the policies and guidelines of Seeds of Jesus Daycare, LLC.
We agree to abide by all policies stated in the Parent Handbook. We understood that we will be notified in writing of any changes in these policies. Any complaints, concerns, or grievances against Seeds of Jesus Daycare, LLC will be made in writing and will followed up in a timely manner.
We also understand that any breach of the policies may be grounds to terminate childcare. A two-week notice will be given in such circumstance unless the infraction is severe enough to warrant termination without notice.

This arrangement will come into effect on _____.

Parent/Guardian Signature _____.

Parent/Guardian Signature _____.

SOJD Signature _____ Position _____.

Today date _____.

# RED CLAY CONSOLIDATED SCHOOL DISTRICT

**ASQ INVITATION LETTER**

Seeds of Jesus # 1236191

Dear Families:

Because the first 5 years of life are so important, we want to help you provide the best start for your child. Red Clay Consolidated School District is collaborating with the DDOE and implementing an online screening measure to help parents track their child's development. The ASQ (Ages & Stages Questionnaire) is a set of questionnaires designed for parents/caregivers to complete. We are inviting you to participate in the ASQ online screening. There are 2 components to the ASQ. One set of questions (ASQ:3) focuses on school readiness and the other set of questions (ASQ-SE:2) focuses on social/emotional development. Both areas of development are very important. **We are asking that you please complete both portions of the ASQ.** Our district also collaborates with the Birth to Three Early Intervention program. Parents of infants and toddlers in our district can screen their child using the link provided below. **Once you have completed and submitted your child's screening you will receive the results via email with any follow-up information.**

**To get started, please choose the appropriate link/QR code based on your child's age-group below.**

## FOR CHILDREN 1 MONTH- 34 MONTHS

https://www.asqonline.com/family/c84b52

Select the first option "I am completing the ASQ: 3 and the ASQ: SE2"

Scan & Complete

## FOR CHILDREN 35 MONTHS- 72 MONTHS

https://www.asqonline.com/family/9f1da1

Select the first option "I am completing the ASQ: 3 and the ASQ: SE2"

Once you complete the questionnaires, we will review your child's results and **send them to the email you provided.** If you have any questions about your child's results, or screening please use the contact information below.

Sincerely,

Jocelyn Tietze, Screening Coordinator, Jocelyn.Tietze@redclay.k12.de.us (302) 492-7749
Red Clay Consolidated School District Early Years Program 99 Middleboro Rd. Wilmington, DE 19804

**STATE OF DELAWARE**
**DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH AND THEIR FAMILIES**
**OFFICE OF CHILD CARE LICENSING (OCCL)**

## ACCIDENT OR INJURY REPORT

**INSTRUCTIONS:** Each accident/injury that occurs to a child while on the premises must be documented and a report must be provided to the parent/guardian/authorized release within one business day. If a child receives medical or dental treatment, other than first aid provided by the facility, due to a known accident/injury that occurred while in the facility's care, call OCCL within one business day to provide notification. After this notification, submit the accident/injury report to OCCL within three business days.

Name of Facility or Provider | Telephone Number

Facility Address (Street, City, Zip Code) | County

Name of Injured Child | Home Address (Street, City, Zip Code) | Date of Birth

Sex: [ ] Male [ ] Female

Name of Witness (if more than one, print on back) | Telephone

Accident or Injury | Accident Location, Date, and Time

Describe Accident or Injury

Time & Date Parent/Guardian was notified, Method of contact and by whom

Message(s) left [ ] Time(s): _____ Contact by whom: _____

What caused the accident to happen? | What was the child doing?

What first aid was given and/or action taken?

What corrective action was taken, if any, to prevent a similar occurrence in the future? (e.g. rug was removed)

**For medical/dental treatment only: If provided by parent, attach the discharge papers upon the child's return.**

How was accident or injury diagnosed by physician? | Were any handicaps, health problems, or exceptions listed on child's health records? [ ] Yes [ ] No
If "yes," please explain on back of form:

Signature of Parent/Guardian/Authorized Release | Date

Signature of Person completing the form | Date

Signature of Administrator/Curriculum Coordinator/Owner | Date

Delaware Department of Education
Child and Adult Care Food Program (CACFP)

# CHILD INCOME ELIGIBILITY FORM

## PART 1 *(Complete one application per household. Please use a pen, not a pencil.)*

Definition of **Household Member**: "Anyone who is living with you and shares income and expenses, even if not related."

Children in **Foster care** and children who meet the definition of **Homeless, Migrant** or **Runaway** are eligible for free meals. Read **How to Apply for Free and Reduced Price School Meals** for more information.

| Child's First Name | MI | Child's Last Name | Date of Birth | Ethnicity Hispanic or Latino? Yes | No | Race (check one or more) American Indian or Alaskan Native | Asian | Black Or African American | Native Hawaiian or Other Pacific Islander | White | Foster Child | Homeless, Migrant, Runaway |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## PART 2 - ENROLLMENT

| Start Date: | | Arrival Time: | | AM/PM | Departure Time: | | AM/PM | Shift Work: | Yes/No |
|---|---|---|---|---|---|---|---|---|---|

***Normal* days of week Participant(s) is/are in care** *(circle all that apply)*: **Mon** **Tues** **Wed** **Thurs** **Fri** **Sat** **Sun**

**Meals eaten at Providers/Center:** *(Circle all that apply. CACFP provides reimbursement for up to 2 approved meals and one snack per day/participant)*:

**Breakfast** **AM Snack** **Lunch** **PM Snack** **Supper** **Evening Snack**

## PART 3 – HOUSEHOLD INCOME

Do any Household Members (including you) currently participate in one or more of the following assistance programs: SNAP or TANF?
Check one: ☐ Yes / ☐ No

**If you answered NO** – Complete Part 3. **If you answered YES** – Write a case number below, then go to Part 4
**Case Number**: (Write only one case number in this space)

**A. Child Income**
Sometimes children in the household earn income. Please include the TOTAL income earned by all Child Household Members listed in PART 1 here.

| Child Income | How Often? Weekly | Bi-Weekly | 2x Month | Monthly |
|---|---|---|---|---|
| $ | ☐ | ☐ | ☐ | ☐ |

**B. All Adult Household Members (including yourself)**
List all Household Members not listed in Part 1 (including yourself) **even if they do not receive income**. For each Household Member listed, if they do receive income, report total income for each source in whole dollars only. If they do not receive income from any source, write "0". If you enter "0" or leave any fields blank, you are certifying (promising) that there is not income to report.

| Name of Adult Household Members (First/Last) | Earnings from Work (Before Deductions) | How Often? Weekly | Bi-Weekly | 2x Month | Monthly | Public Assistance/ Child Support/ Alimony | How Often? Weekly | Bi-Weekly | 2x Month | Monthly | Pensions/SSI/ Retirement/ All Other Income | How Often? Weekly | Bi-Weekly | 2x Month | Monthly |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | $ | ☐ | ☐ | ☐ | ☐ | $ | ☐ | ☐ | ☐ | ☐ | $ | ☐ | ☐ | ☐ | ☐ |
| 2 | $ | ☐ | ☐ | ☐ | ☐ | $ | ☐ | ☐ | ☐ | ☐ | $ | ☐ | ☐ | ☐ | ☐ |
| 3 | $ | ☐ | ☐ | ☐ | ☐ | $ | ☐ | ☐ | ☐ | ☐ | $ | ☐ | ☐ | ☐ | ☐ |
| 4 | $ | ☐ | ☐ | ☐ | ☐ | $ | ☐ | ☐ | ☐ | ☐ | $ | ☐ | ☐ | ☐ | ☐ |
| 5 | $ | ☐ | ☐ | ☐ | ☐ | $ | ☐ | ☐ | ☐ | ☐ | $ | ☐ | ☐ | ☐ | ☐ |

## PART 4 – CONTACT INFORMATION and ADULT SIGNATURE

An adult household member must **sign and date** this form before it can be approved.
"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

| **Total Household Members** (Children and Adults) | | **Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household** * * * - * * - ____ | Check if No SSN ☐ |
|---|---|---|---|

| Street Address (if available) | City | State | Zip | Daytime Phone and Email (optional) |
|---|---|---|---|---|
| Printed Name of adult completing the form | Signature of adult completing the form | | | Today's Date |

## SPONSOR USE ONLY:

**Categorical Eligibility (If Yes, Check One)**: ☐ SNAP (Food Stamp) Household
☐ TANF Household ☐ Head-Start ☐ ECAP ☐ Foster Child(ren) ☐ Homeless/Migrant/Runaway Participant(s)

**DATE WITHDRAWN:** _____

Total Family Income: _____ Family Size: _____ (Include all Participants)
*Yearly Income Conversion:* ***Weekly x 52; Every Two Weeks x 26; Twice a Month x 24; Monthly x 12***

**ELIGIBILITY - Based on the information provided this application will be:**
☐ Approved FREE ☐ Approved REDUCED ☐ Denied – The meals will be claimed in the PAID category.

Determining Official Signature: _____ Review/Effective Date: _____