Classroom Emergency Information

Child's Full Name _____

Date of Birth ____/____/____. Male ( ) Female ( )

( ) American Indian/Alaskan Native	( ) Asian or Pacific Islander
( ) Black (Not of Hispanic Origin)	( ) Hispanic
( ) White (Not of Hispanic Origin)	( ) Multi-Racial

	Parent 1 or Guardian	Parent 2 or Guardian
Name		
Address		
City/State/Zip		
Home Phone		
Employer		
Occupation		
Work Phone		
Cell#/Beeper		
Email		

Allergies/Special Needs_____

_____

Only the people listed below (other than parents or guardians) are allowed to pick-up my child at the school. In the event of an emergency, these people can be called if parents are not available.

Name Street Address City, State, Zip Home # Work # Relationship

_____

_____

_____

The Clifton School
Infant Feeding Plan

Child's Name_____ Date_____

Birthday_____

Does the child take a bottle? Yes [ ] No [ ]

Is the bottle warmed? Yes [ ] No [ ]

Does the child hold own bottle? Yes [ ] No [ ]

Can the child feed self? Yes [ ] No [ ]

Does the child eat:

Strained foods [ ] Whole milks [ ]

Baby foods [ ] Table foods [ ]

Formula [ ] Other [ ]

What type of formula is used? _____

Amount of formula to be given? _____

Updated amounts of formula:

Date	Amount

Does the child take a pacifier? Yes [ ] No [ ]

When?_____

Food Likes_____ Food Dislikes_____

Allergies including any pre-mixed formulas_____

Child's Feeding Schedule

	Time	Types and approximate food amount
Breakfast		
Lunch		
Dinner		
Morning Nap		

Instructions for the introduction of solid foods:

_____

_____

As needed, please list updated instructions regarding adding new foods or other dietary changes.

Parent/Guardian Signature_____ Date_____

The Clifton School Infant Food Chart

Name of Child_____

Please initial and place date by the following stage 2 foods you would like your child to be fed while attending school. Please try them at home for at least three (3) days before initialing.

Example: DR 04/24/12 Carrots

Vegetables

_____Carrots

_____Green Vegetables

_____Mixed Vegetables

_____Peas

_____Squash

_____Sweet Potatoes

Breads/Cereals

_____Cheerios

_____Goldfish

_____Graham Crackers

_____Oatmeal Cereal

_____Vanilla Wafers

_____Whole Wheat

_____Other: _____

Fruits

_____Applesauce

_____Bananas

_____Peaches

_____Pears

Meats

_____Beef

_____Chicken

_____Turkey

_____ _____

Parent Signature Date

The Clifton School

Infant Formula Permission Form

The Clifton School participates in the CAFP (Child and Family Care Food Program) and serves well balanced meals that meet USDA meal pattern requirements.

In order to meet the requirements of this Federal program, The Clifton School provides **Similac Advance Optigrow with Iron.** Parents may choose to use this formula, or they may provide formula or breastmilk they are currently feeding their child.

If parents choose to use **Similac Advance Optigrow with Iron**, they must bring enough clean, clearly labeled, empty bottles for their child's daily use. The Infant Village staff will pour the pre-mixed formula into the empty bottles at the time of service.

The center will also provide rice and oatmeal cereal and baby food.

Please indicate below your preference regarding your formula choice.

_____ Yes, I want The Clifton School to provide and feed my child **Similac Advance Optigrow with Iron.**

_____ No, I do not want The Clifton School to provide and feed my child **Similac Advance Optigrow with Iron.** I will provide formula or breast milk for my child.

_____

Child's Name

_____ _____

Parent Signature **Date**

The Clifton School

Safe Sleep Practices Policy

Child's Name:_____ Date of Birth:_____

Parent/Guardian Name:_____

Safe Sleep Practices/Policies:

1.) Infants will be placed on their backs in a crib to sleep unless a physician's written statement authorizing another sleep position for that infant is provided. The written statement must include how the infant shall be placed to sleep and a time frame that the instructions are to be followed.

2.) Cribs shall be in compliance with CPCS and ASTM safety standards. They will be maintained in good repair and free from hazards.

3.) No objects will be placed in or on the crib with an infant. This includes, but is not limited to, covers, blankets, toys, pillows, quilts, comforters, bumper pads, sheepskins, stuffed toys, or other soft items.

4.) No objects will be attached to a crib with a sleeping infant, such as, but not limited to, crib gyms, toys, mirrors, and mobiles.

5.) Only sleepers, sleep sacks and wearable blankets provided by the parent/guardian and that fit according to the commercial manufacturer's guidelines and will not slip up around the infant's face may be worn for the comfort of the sleeping infant.

6.) Individual crib bedding will be changed daily, or more often as needed, according to the rules. Bedding for cots/mats will be laundered daily or marked for individual use. If marked for individual use, the sheets/covers must be laundered weekly or more frequently if needed.

7.) Infants who arrive at the center asleep or fall asleep in other equipment, on the floor, or elsewhere, will be moved to a safety-approved crib for sleep.

8.) Swaddling will not be permitted, unless a physician's written statement authorizing it for a particular infant is provided. The written statement must include instructions and a time frame for swaddling the infant.

9.) Wedges, other infant positioning devices and monitors will not be permitted unless a physician's written statement authorizing its use for a particular infant is provided. The written statement must include instructions on how to use the device and a time frame for using it.

I acknowledge that the director or designee has advised me of safe sleep practices followed by the facility.

Signature_____ Date_____

Authorization to Dispense External Preparations
590-1-1-.20(1)

Parental Authorization. Except for first aid, personnel shall not dispense prescription or non-prescription medications to a child without specific written authorization from the child's physician or parent. Such authorization will include, when applicable, date; full name of the child; name of the medication; prescription number, if any; dosage; the dates to be given; the time of day to be dispensed; and signature of parent.

I, _____ give **The Clifton School** staff permission to apply one or more of the following topical ointments/preparations to my child, _____ in accordance with the directions on the label of the container.

_____ Baby Wipes

_____ Band-aids

_____ Neosporin or similar ointment

_____ Bactine or similar first aid spray

_____ Sunscreen

_____ Insect Repellent

_____ Non-Prescription ointment (such as A & D, Desitin, Vaseline)

_____ Baby Powder

Other (please specify) _____

_____ _____
Parent/Guardian Signature Date

Culture, Traditions and Beliefs Form

Child's
Name_____DOB_____

In the space below (use the back if additional space is needed) please share any information regarding your culture, traditions, beliefs and values and/or family traditions that you feel would be helpful with your child's transition to school.