Betty J. Taylor Early Learning Academy 2024-2025 Registration Packet

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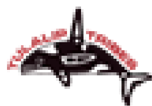
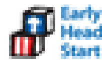
All forms in red are separate from this packet.





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Parent Acknowledgement Form

2024-25 School Year

Child's Name: ____

Parent/Guardian Name: ____

In order to ensure that our parents clearly understand our policies and procedures, we require all parents to read the Parent Handbook and sign below to acknowledge that they have received and read a copy of the BJTELA Parent Handbook.

Please initial each acknowledgement and sign at the bottom.

_____ I acknowledge that I have read, reviewed, and agree to abide by the Attendance Policy.

_____ I acknowledge that I have read, reviewed, and agree to abide by the Extended Care Services section of the parent handbook.

_____ I acknowledge that I have read, reviewed, and agree to abide by the Child Abuse and Neglect Training.

_____ I acknowledge that I have read, reviewed, and agree to abide by the Communication with Families and Confidentiality sections of the parent handbook.

_____ I acknowledge that I have read, reviewed, and agree to abide by the BJTELA Health and Safety Policies which are listed below:

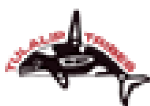
- _____ Emergency Preparedness
- _____ Child Safety Policy
- _____ Biting Policy
- _____ Accident/Illness Report Forms
- _____ Health Attendance
- _____ Disease Exclusion
- _____ Medication Administration
- _____ Head Lice
- _____ Immunization
- _____ Smoke and Drug Free Environment

_____ I acknowledge that I have read, reviewed, and agree to abide by the Parent Code of Conduct, Parent Complaint Policy and Process, and Security Camera Policy.

_____ I acknowledge that I have read, reviewed, and agree to abide by the Parent Agreement.

By signing this, I acknowledge that I have received and read a copy of the BJTELA Parent Handbook. I also agree to abide by the policies set in the handbook.

Parent/Guardian Signature: ____ Date: ______________



Emergency Consent

Child Information

Childs Name: ______________________ Date of Birth: ______________

Address: ____

Parent Information

Parent/Legal Guardian:		Parent/Legal Guardian:	
Cell Phone:		Cell Phone:	
Work Phone:		Work Phone:	
Email:		Email:	
Signature:		Signature:	

Custody Concern:

Name ______________________ Relationship ______________________

Situation ____

In an emergency if a parent or legal guardian cannot be reached, contact the following who also has permission to pick up my child:

Name:		Name:	
Phone:		Phone:	
Relationship:		Relationship:	

Other than you, and the emergency contacts listed above, who else has permission to pick up your child?

Name:		Phone:	
Name:		Phone:	
Name:		Phone:	
Name:		Phone:	

Child's Doctor:		Phone:	
Child's Dentist:		Phone:	

Medical Coverage: Medical Coupons: ______________ Other: ______________

(Case Number) (Co. Name & Coverage #)

Child currently on any medication? No ______ Yes ______ If yes, list: ______________

Reason: ____

Ongoing Medical / Health Concerns? No ______ Yes ______ If yes, list: ______________

If yes, have you filled out an Individualized Health Care Plan?

Allergies? No ______ Yes ______ If yes, list: ______________

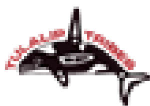
Allergies to medication? No ______ Yes ______ If yes, list: ______________

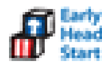
Allergies to Food? No ______ Yes ______ If yes, list: ______________

If your child has allergies to food, have you filled out the CACFP Form?

Immunization Exemption? No ______ Yes ______ If yes, have you filled out the Immunization Exemption Form?

Children of the Salmon





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Parental Consent

Should an emergency arise involving your child, a conscientious effort will be made to locate you in order to provide medical or dental care to your child in your absence, written consent is required. **<u>Please read the following consents carefully and initial each section to indicate that you understand</u>. <u>Then sign your name.</u>**

__________ (Initials) I give my permission for a qualified staff member to administer first aid/CPR to my child if deemed necessary by BJTELA staff.

__________ (Initials) In an emergency, if deemed necessary by BJTELA staff, I give BJTELA my permission to transport my child by ambulance or rescue squad to a licensed physician, clinic or emergency room of an accredited hospital.

__________ (Initials) In the event that I cannot be contacted, I consent to medical, dental, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, dentist, or hospital when deemed immediately necessary by the physician to safeguard my child's health.

__________ (Initials) I authorize BJTELA staff to use my name and my child's name in email communication with me regarding BJTELA. I understand that email is not confidential, and consent to the use of names with that understanding.

<u>Parental Consent</u>

BJTELA requires written consent for your child to participate in the activities listed below which are designed to enhance your child's school experience. I give my permission for the students named on this registration to participate in the following activities:

Read the following and <u>initial</u> each item to state you understand and give your approval. Not initialing means you do not approve.

<u>Transportation</u>

_______ To go on spontaneous walks without advance notice for educational experience.
_______ To be transported on program field trips about which I have been notified in advance.

<u>Health, Dental and Developmental Screenings</u> (Required by Performance Standards)
I understand Health and Developmental Screenings are a requirement of BJTELA. I authorize my child's participation in the screening process including:

_______ Completing development, social/emotional and health screenings (height, weight, vision and hearing) and classroom observations conducted by the BJTELA staff and consultants.

<u>Non-Medical Items</u>

_______ I give permission for my child to participate in daily tooth brushing
_______ I give permission for my child to receive applications of sunscreen following the manufacturer's instructions
_______ I give permission for my child to receive applications of diaper ointments. (Children in our Birth to Three Program)
_______ I give permission for my child to receive applications of lip balm or lotion following manufacturer's instructions.
_______ I give permission for my child to use hand sanitizer or hand wipes with alcohol. (Only children 2 years of age or older)

<u>Outside Agencies</u>

_______ For my child to be observed as part of classroom observations conducted for Early Achievers and for other professional agencies.

<u>Photo/Media</u>

_______ For my child to be photographed and/or videotaped for academy/educational purposes.

<u>Cultural Foods</u>

_______ For my child to participate in trying traditional foods provided as part of language and culture curriculum

I understand that I have the right of access, review, and discussion on all information regarding my child with the appropriate staff person and/or consultant. I give permission for all the items that I have initialed.

____ ______________________
Signature of Parent or Legal Guardian Date

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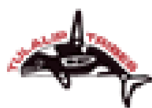

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Fluoride Varnish Consent Form

☐ **YES, I would like my child's teeth varnished for free.**

☐ **NO, I would not like my child's teeth varnished for free.**

Please fill out the rest of this form only if you would like your child to receive a dental varnish (print clearly).

I authorize the Tulalip Dental Clinic of Tulalip Washington, and any other person associated or assisting them to proceed with administering the fluoride varnish that will help prevent cavities on my child's teeth.

Children of the Salmon

Student Name (first and last): ____

Date of Birth: ____

Street Address: ____

City/State: Zip Code: ____

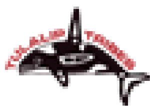
Phone Number: ____

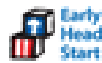
______________________________ ______________________ ______________________

Parent/Guardian Signature | Relationship to Student | Date Signed

WHAT IS FLUORIDE VARNISH?

Fluoride varnish is an easy, effective, and safe way to help protect your child's teeth and prevent cavities. The varnish is a liquid coating that is painted on your child's teeth with a brush. It dries instantly and only takes minutes to apply. The varnish releases fluoride over several months, which strengthens teeth and helps prevent decay.





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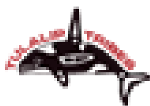

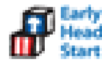

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Health PIR Form

Child's Name: ____

School Year: **2024-25**

Parent/Guardian(s): ______________________________________

Health Insurance:

___Child Has Health Insurance

- __Enrolled In Medicaid and/or CHIP Apple Health
- __Enrolled In State-Only Funded Insurance (e.g., Medically Indigent Insurance/IHS)
- __Enrolled In Private Health Insurance (e.g., Parent's Insurance)
- __Enrolled in Other e.g., Military Health (Tri-Care or CHAMPUS)
  Specify:____________________

___Child Has No Health Insurance

Diagnosed Chronic Conditions:

___ Anemia______Asthma______Autism spectrum disorder

___Diabetes_____High Lead Levels _____ ADHD

____Hearing Difficulties______Vision Difficulties

____Life-Threatening Allergies _______ Seizures _____ Other

(Please Specify:_________________________)

Medical Home:

__Child Has Ongoing Source of Continuous, Accessible Health Care

__Child Receiving Medical Services Through Indian Health Services

__Child Receiving Medical Services Through A Migrant Community Health Center

Dental Home:

__Child Has Continuous Accessible Dental Care

__Child Does Not Have Accessible Dental Care

Medical Services:

____Child Is Up-To-Date On Scheduled Age-Appropriate Preventive And Primary Health Care

___Child Has Been Diagnosed With Chronic Condition Needing Medical Treatment

Received Or Receiving Medical Treatment For Condition

___Child Has Not Received Needed Medical Treatment For Condition, Due To:

- ___No Health Insurance
- ___Parent Did Not Keep/Make Appointment
- ____No Pediatric Care In Local Area
- ___Appointment Scheduled For Future Date
- ___Medicaid Not Accepted By Provider
- ___No Transportation
- ____Other
  (Please Specify:______________________________)

WCC Turned In:

_____2 Weeks_______2 Months _____4 Months _____6 Months
_____9 Months_______12 Months______15 Months______18 Months
_____2 Year______3 Year_____4 Year_____5 Year

Immunization Services:

_____Up-To-Date On All Immunizations Appropriate For Age

_____Has Received All Immunizations Possible At This Time, But Has Not Received All Immunizations Appropriate For Age

_____Child Is Exempt From Immunizations

Infant & Toddler Preventive Dental Services:

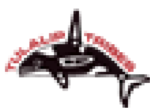
____Child Is Up-To-Date On Scheduled Age-Appropriate Preventive And Primary Oral Health Care

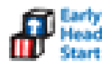
Notes:

_______Parent/Guardian provided Individual Health Care Plan Packet
________Health Staffing Needed

______Please review immunizations
_________Please review well child

_______HIPPA Authorization Form Signed
________Allergies





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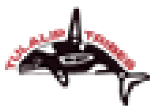

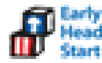

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Child Nutrition History

1. **Is your child allergic to any foods?** — **Yes** **No**
   If yes, which foods?
2. Has a doctor/nurse/nutritionist suggested any special diet for your child? — **Yes** **No**
   If yes, please explain:
3. Does your child take vitamin/mineral supplements at home? — **Yes** **No**
   If yes, is iron included?
4. Does your child have trouble chewing or swallowing? — **Yes** **No**
   If yes, please explain:
5. Are there foods that cannot be eaten for cultural, religious or medical reasons? — **Yes** **No**
   If yes, which foods?
6. Have there been any changes in your child's appetite during the last three months? — **Yes** **No**
   If yes, please explain:
7. Do you have any concerns about your child's eating habits? — **Yes** **No**
   If yes, please explain:
8. Do you have any concerns about your child's growth? — **Yes** **No**
   If yes, please explain:
9. Do you have any concerns about your child's weight? — **Yes** **No**
   If yes, please explain:
10. Do you share meals together as a family? — **Yes** **No**
11. Does your child eat non-food items? — **Yes** **No**
    If yes, list:

Children of the Salmon

Child's Name: ______________________________ Date of Birth: ______________

Parent Signature: ______________________________ Date: ______________

Parent Name: ______________________________

Staff Signature: ______________________________ Date: ______________

General Health History

Child's Name: ____ **Sex:** M F **DOB:** _________________________

Pregnancy/Birth History	**Yes**	**No**	**Explain "Yes" Answers**
1. Did the mother have any health problems during pregnancy or during delivery of this child?			
2. Did the mother visit a physician fewer than two times during the pregnancy?			
3. Was the child born outside of a hospital?			
4. Was the child born more than three weeks early or late?			
5. What was the child's birth weight?	---	---	lbs. oz.
6. Was anything wrong with the child at birth?			
7. Was anything wrong with the child in the nursery?			
8. Did the child or mother stay in the hospital for medical reasons longer than usual?			
9. Is the mother pregnant now?			
Hospitalizations and Illness	**Yes**	**No**	**Explain "Yes" Answers**
10. Has the child ever been hospitalized or operated on?			
11. Has your child had any of the following?			
12. Asthma or other breathing issues?			
13. Any life-threatening allergies?			
14. Seizures/other neurological issues?			
15. Heart/other cardiovascular issues?			
16. Diabetes or other endocrine concerns?			
17. Bone or joint issues?			

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18. Eczema or skin issues?			
19. Frequent ear infections or tubes?			
20. Other ear, nose or throat concerns?			
21. Tuberculosis exposure?			
22. Bladder, bowel/urinary tract concerns?			
23. Frequent, heavy nosebleeds?			
24. Injury or abuse?			
25. Second-hand smoke exposure?			
26. Do you have concerns with your child's behavior?			
27. Other, please explain:			
Health Problems	**Yes**	**No**	**Explain "Yes" Answers**
28. Has the child ever had convulsions or a seizure? Is the child taking medicine for seizures?			
29. Do any of the conditions we have talked about get in the way of the child's everyday activities?			
30. Are there any conditions we have not talked about that get in the way of the child's everyday activities? Did a doctor or health professional tell you that the child has this problem?			
Parent/Family	**Yes**	**No**	**Explain "Yes" Answers**
31. Do you have any concerns about your child's vision? (*if applicable*) Is the child wearing (or supposed to wear) glasses?			
32. Do you have any concerns about your child's hearing?			
33. Do you have any concerns about your child's speech?			
34. Do you have any concerns about your child's behavior?			
35. Do you have any concerns about your child's development?			

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36. Do you have any concerns about your child/family?			
37. Are cigarettes/other tobaccos used in your home or car?			
38. Is there anything that gets in the way of going to the doctor or dentist? *For example: Time, transportation, no insurance, etc.*			
39. Does your child take a nap? If yes, when and for how long?			
40. Does your child sleep less than 8 hours a day or have trouble sleeping (such as being fretful, having nightmares, wanting to stay up late)? If yes, describe sleeping arrangements?			
41. Does your child use the toilet?			
42. Does your child need help using the toilet during the day or night? (If applicable)			
43. How does your child act with adults that they do not know?	---	---	
44. How does your child act with children their own age?	---	---	
45. Does your child often get cranky or cry when they are not tired, hungry, or sick and you cannot figure out why? a. If yes, can you please elaborate?			
46. Have there been any big changes in your child's life in the last six months?			
Allergies	**Yes**	**No**	**Explain "Yes" Answers**
47. Does your child have allergies or sever reactions (including intolerances) to food, medicine, insects, animals, or other substances? If yes (please answer questions 49-53) If no (please skip to next section)			
48. Please name what your child is allergic to and describe your child's allergic reaction:			
49. How do you treat your child's allergy? Please list any over-the-counter medications you use at home, if any.			
50. Has this allergy been diagnosed by a licensed healthcare provider?			

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	Yes	No	Explain "Yes" Answers
51. Do you have epinephrine or any prescription medication at home to treat your child's allergy?			
52. Additional information about allergies?			
Medication	**Yes**	**No**	**Explain "Yes" Answers**
53. Does your child take medication on a regular basis?			
54. Would any medications be required at school? Name of medication(s), dosage and when taken:			
Health Services Provider	**Yes**	**No**	**Explain "Yes" Answers**
55. Does your child currently have health insurance?			
56. Who is your child's health care provider?	---	---	Name: Phone: Office Name: City:
57. How long has this agency or physician provided services to your child?	---	---	
Dental History	**Yes**	**No**	**Explain "Yes" Answers**
58. Who is your child's dental care provider?			Name: Phone: Office Name: City:
59. How long has your child been receiving services from this dentist?	---	---	
60. How would you rate your child's dental health?	---	---	Very Good Somewhat Good Fair Somewhat Bad Very Bad
61. Has your child ever had an injury to the teeth and/or mouth?			
62. Does your child complain about tooth or mouth pain?			
63. Other dental concerns?			

Parent/Guardian Signature:____**Date:** __________________

Relationship to child: ____

Staff Signature:____**Date:**___________________

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Screening Letter

Dear BJTELA Family,

Welcome to our screening and monitoring process. A child's first five years of life are important in their development. It is our goal to help provide your child with the best start. Here at the Betty J. Taylor Early Learning Academy we begin every school year by assessing your child. We use the Ages and Stages Questionnaires, Third Edition (ASQ-3), to help check your child's process throughout their development. A questionnaire will be given to you within the first 45 days of service. In this assessment you will be asked to evaluate your child on their communication, gross motor, fine motor, problem solving and personal-social skills. The teacher will also be answering the same questionnaire on your child, within the first 45 days of services.

Another screening tool we use is Ages and Stages Questionnaires: Social Emotional (ASQ-SE). The ASQ-SE measures your child's behavior. You will also complete this questionnaire within the first 45 days of service and so will your child's teacher. This is a parent/teacher completed, monitoring system for social emotional behaviors. This tool will help us further evaluate your child and those who are developing typically.

If this questionnaire shows a possible concern, we will contact you about further assessment for your child, at that time. Information will only be shared with Child Strive.

With your signature below, you are giving permission to further assess your child, if further assessment is needed.

Sincerely,

Betty J. Taylor Early Learning Academy Staff

Child's Name: ____

Parent/Guardian Signature: ____

Relationship to Child: ____

Date: ____

Children of the Salmon