Admission Date: Termination Date:

Child's Name:	
DOB:	Child's Address:
Your Relationship to Child:	Your Relationship to Child:
Parent/Guardian Name:	Parent/Guardian Name:
SSN:	SSN:
Address:	Address:
Homephone #:	Homephone #:
Cellphone #:	Cellphone #:
Work #: Employer:	Work #: Employer:

Other than you, who else has your permission to pick up your child:

Name	Relationship to Child	Phone #

The laws of the State of Washington require providers including Rainbow River to report any suspected child abuse or neglect.

Health History: Date of Last Physical Exam:

Allergies/Medication:

Doctor/PNP	Address	Phone #

Dentist(if have one)	Address	Phone #

In case of emergency what steps would you like Rainbow River staff to take?

(Suggestion: Administer 1st Aid, Call 911, and then call emergency numbers provided.)

Emergency Contact (Family, Friend):

Days and times my child will receive care:

	Monday	Tuesday	Wednesday	Thursday	Friday
Arrival Time:					
Departure Time:					

Fee: $ _____Day _____Week _____Month Source of Payment: _____Parent _____DSHS _____Other

Payment due the 1st of every month Late Fee: 5% on balance after the 16th of every month

Overtime Rate: $ 2.00 per minute per child after 5:30 pm and/or after scheduled departure time (pick-up time)

I agree that my child will only attend Rainbow River during the scheduled days and times which will not exceed ten (10) hours a day.

I agree to promptly notify Rainbow River of any changes of the above information.

I understand that I am fully responsible for the terms of this agreement as stipulated.

I have read, understood, and agree to comply with the policy and procedures (Parent Handbook) given to parents at Rainbow River.

Parent/Guardian Signature Date

I agree to provide childcare services according to the above plan and to promptly notify parent(s)/guardian(s) of any changes to the above information.

Provider Signature Date

Child and Adult Care Food Program
ENROLLMENT/INCOME-ELIGIBILITY APPLICATION

PART 1 – CHILDREN'S INFORMATION—Required for all children in care.

Child's Name	Birthdate	Age	Circle Normal Days/ Print Normal Hours of Care	Circle Meals and Snacks Normally Received
			Sun Mon Tu Wed Th Fri Sat Normal Hours __ to __	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours __ to __	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours __ to __	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours __ to __	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack

INCOME ELIGIBILITY

Please check the boxes that apply to help determine the other parts of this form to complete:

☐ A family member in our household receives benefits from Basic Food, TANF, or FDPIR. (Please complete Part 2 and 5.)

☐ One or more of the children in Part 1 is a foster child. (Please complete Part 3 and 5.)

☐ My child(ren) may qualify for Free/Reduced-Price meals based on household income. (Please complete Part 4 and 5.)

☐ My child(ren) will not qualify for Free/Reduced-Price meals. (Please complete Part 5 only.)

PART 2 – HOUSEHOLD MEMBER RECEIVING BASIC FOOD/TANF/FDPIR— **Any household member receiving benefits can establish eligibility for all children in the household.**	**Case Number or Identification Number**

PART 3 – FOSTER CHILDREN—List the names of any children listed in Part 1 who are foster children.

PART 4 – TOTAL HOUSEHOLD GROSS INCOME FROM LAST MONTH—Not required if you have reported a case number in Part 2.

Tell us how much and how often. If no income, write "0". Use net income if self-employed.

List names (First and Last) of everyone in your household, including foster children	Earnings from Work Before Deductions	Weekly	Every 2 Weeks	2X Monthly	Monthly	Welfare, Alimony, Child Support	Weekly	Every 2 Weeks	2X Monthly	Monthly	Retirement, Pensions, Social Security, Other	Weekly	Every 2 Weeks	2X Monthly	Monthly
1.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
2.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
3.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
4.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
5.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
6.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐

PART 5 – SIGNATURE AND CERTIFICATION—REQUIRED

The adult household member who fills out the application must sign below. If Part 4 is completed, the adult signing the form must also list the last four digits of his/her Social Security Number (SSN) or check the box if no SSN. *See Privacy Act Statement on the back of this page.*
If you have listed a case number in Part 2 or are applying on behalf of a foster child, or have checked the box that your child(ren) will not qualify for Free/Reduced-Price meals, the last four digits of the SSN is not needed.
"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, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Signature of Adult X________________	**Today's Date** ________________	**Print Name of Adult Signing** **Social Security Number (SSN) (last four digits)** XXX-XX- ☐ Check if no SSN
Address	**City/State/Zip Code**	**Daytime Phone**

Food Preference Sheet

IF NOT APPLICABLE PLEASE LEAVE BLANK.

Child's Name:_____

Food Preference (please state what foods you prefer to give/ not give your child):

_____

_____

_____

_____

_____

☐ Personal Preference

☐ Religious Preference

☐ Other Preference

Parent Name:_____ Date:_____

Parent Signature:_____

* IF NOT APPLICABLE PLEASE LEAVE BLANK *

Washington Office of Superintendent of
PUBLIC INSTRUCTION

Request for Fluid Milk Substitution – Child Care

Child's Name: _____

Milk substitution request:

If your child cannot drink fluid cow's milk due to medical or other special dietary needs but **does not** have a diagnosed medical disability, you or the child care center may choose to provide one of the approved non-dairy milk substitutes or creditable milk substitutes below, based on your request.

Identify why your child needs a milk substitute: _____

_____

At this time, six brands of non-dairy milk substitutes available in Washington are nutritionally equivalent to and may be served in place of cow's milk:

- 8th Continent Soymilk - Original and Vanilla*
- Silk Soymilk - Original
- Great Value Soymilk - Original from Wal-Mart (red top only)
- Kirkland Organic Soy - Original (32-oz shelf-stable)
- Pacific Foods Ultra Soy - Original (32-oz or 8-oz shelf-stable)
- Ripple Dairy-Free Shelf-Stable Milk Original (32-oz or 8-oz), Chocolate* (8-oz) or Vanilla* (8-oz)

***Flavored non-dairy beverages cannot be served to children 1 through 5 years of age.**

Other milks that are creditable and may be served in place of fluid cow's milk are acidified milk, acidophilus milk, buttermilk (commercially prepared), goats milk, Kefir milk, lactose-free or reduced milk (such as Lactaid), and organic milk. **Note: Whole milk must be served to children 12 to 24 months and nonfat or 1% milk must be served to children 2 years of age or older.**

By completing the information below, your child can be served one of the approved non-dairy milk substitutes or other creditable milks noted above provided by the center (if the center chooses), or provided by you.

_____ I request my child be served the child care center provided approved non-dairy or creditable milk substitute as described above for meals that require milk.

_____ I will provide an approved non-dairy or creditable milk substitute to be served to my child as described above for meals that require milk:

_____
(Name of approved non-dairy or creditable milk substitute)

Signature of Parent/Guardian: _____ Date: _____

* IF NOT APPLICABLE PLEASE LEAVE BLANK *

Public Health
Seattle & King County

Child Care Emergency Plan for Allergic Reactions

ALLERGY TO: _____

Student's Name: _____ D.O.B: _____

Asthma Yes* ☐ No ☐ *High Risk for severe reaction

SIGNS OF AN ALLERGIC REACTION:

Systems	Symptoms
• MOUTH	itching & swelling of the lips, tongue, or mouth
• THROAT	itching and/or a sense of tightness in the throat, hoarseness and hacking cough
• SKIN	hives, itchy rash, and/or swelling about the face or extremities
• GUT	nausea, abdominal cramps, vomiting, and/or diarrhea
• LUNG	shortness of breath, repetitive coughing, and/or wheezing
• HEART	"thready" pulse, "passing-out"

The severity of symptoms can quickly change. All the above symptoms can potentially progress to a life-threatening situation.

Action for *minor* reaction:

If symptom(s) are: _____

☐ **Administer:** _____
medication/dose/route

☐ **Then call: Parent/Guardian and Health Care Provider**

☐ **If condition does not improve within 10 minutes, follow steps for Severe Reaction below:**

Action for *severe* reaction:

If symptom(s) are: _____

☐ **Administer:** _____ **IMMEDIATELY!**
medication/dose/route

☐ **Call: 911 (Never hesitate to call 911)**

☐ **Call: Parent or Guardian**

☐ **Call: Health Care Provider**

Parent/guardian name _____ phone # _____

Parent/guardian signature _____ Date: _____

Health Care Provider name _____ phone # _____

Health Care Provider signature (Required) _____ Date: _____

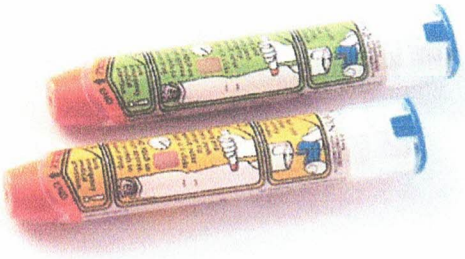
* IF NOT APPLICABLE PLEASE LEAVE BLANK *

Public Health
Seattle & King County

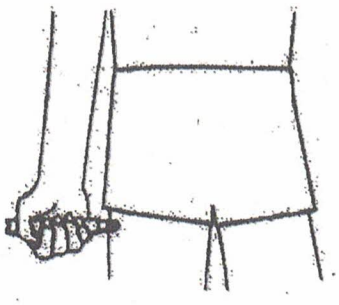
Emergency Contacts	Trained Staff Members
1. _____	1._____Room_____
Relation:_____Phone_____	2._____Room_____
2. _____	3._____Room_____
Relation:_____Phone_____	
3. _____	
Relation:_____Phone_____	

EPIPEN® and EPIPEN® Jr. Directions

1. Pull off blue safety release.



2. Hold orange tip near outer thigh (always apply to thigh).



3. Place firmly against thigh and press until Auto-injector mechanism functions. Hold in place and count to 10. The EpiPen unit should then be removed and taken with you to the Emergency Room. Massage the injection area for 20 seconds.

* IF NOT APPLICABLE PLEASE LEAVE BLANK *

Child Care Health Program
401 Fifth Avenue, Suite 1000
Seattle, WA 98104
206-263-8262 Fax 206-205-6236
TTY Relay: 711
www.kingcounty.gov/health

Public Health
Seattle & King County

Allergy Medication Authorization Form

Child's Name:	Date of Birth:
Type of Allergy:	Age _____ and Weight_____

Name of Medication: **Antihistamine**	Amount/Dose:
Start Date:	Stop Date:
Times to be given: **"See Care Plan"**	Route: **Oral**
Possible Side Effects:	Special Instructions:
☐ Above information consistent with label?	Requires Refrigeration: ☐ yes X no

Name of Medication: **EpiPen**	Amount/Dose:
Start Date:	Stop Date:
Times to be given: **"See Care Plan"**	Route: **Injection**
Possible Side Effects:	Special Instructions:
☐ Above information consistent with label?	Requires Refrigeration: ☐ yes X no

Health Care Provider Signature Date

Health Care Provider Name Phone Number

Parent/Guardian Signature Date

Parent/Guardian Name (1) Phone Number

Parent/Guardian Name (2) Phone Number

* IF NOT APPLICABLE PLEASE LEAVE BLANK *

Medication Record

Medication: Antihistamine

Allergy Reaction Documentation:

1. Symptoms Observed:_____
2. Time symptoms began:_____
3. Time **Antihistamine** given:_____
4. Time parent/Guardian called:_____
5. Symptoms resolved (10 minutes) or worsened? _____
6. Action taken:_____

Date	Time	Dosage	Initials	Reason NOT Given	*Side Effects Observed*

Medication: EpiPen

Allergy Reaction Documentation:

7. Symptoms Observed:_____
8. Time symptoms began:_____
9. Time **EpiPen** given:_____
10. Time 911 called:_____
11. Time parent/guardian called: _____
12. Time Health Care Provider called:_____
13. Child taken:_____(where) by _____(whom).

Date	Time	Dosage	Initials	Reason NOT Given	*Side Effects Observed*

Initials and Signatures of persons giving medication:

_____ _____ _____ _____

Public Health
Seattle & King County

* IF NOT APPLICABLE PLEASE LEAVE BLANK *

Health Care Provider's Allergy/Intolerance Report

_____ _____
Name Of Child Today's Date

This child is enrolled in our child care program. We have been advised that he/she is allergic or intolerant to the following items:

1. _____	5. _____
2. _____	6. _____
3. _____	7. _____
4. _____	8. _____

As a licensed child care program we are required to meet state licensing standards. Please help us to comply and meet the health needs of your patient by completing the Allergy/Intolerance Statement form and if necessary the Child Care Emergency Plan for Allergic Reactions. We need to know which items the child is allergic or intolerant to, the steps to take to treat an allergic reaction, and appropriate substitute foods to assure that the child's nutrition is not compromised.

Thank you for your help in this important health matter.
Sincerely,

_____ _____
Child Care Program Director Child Care Site

_____
Child Care Center Address

By signing below, I indicate my approval to release the information requested above to my child's licensed child care program.

_____ _____ _____
Parent/Guardian Signature Date Parent/Guardian Name (print)

Parent/Guardian Address _____

_____

* IF NOT APPLICABLE PLEASE LEAVE BLANK *

Public Health
Seattle & King County

Name of Child _____ Birthdate_____

(Please print)

Food Allergy: List each food separately	**Check the medical condition**	**List appropriate substitute food(s)**
	Food Intolerance ☐ Yes ☐ No Food Allergy ☐ *Yes ☐ No	
	Food Intolerance ☐ Yes ☐ No Food Allergy ☐ *Yes ☐ No	
	Food Intolerance ☐ Yes ☐ No Food Allergy ☐ *Yes ☐ No	
	Food Intolerance ☐ Yes ☐ No Food Allergy ☐ *Yes ☐ No	

Other Allergy: Please list items:	**Reaction:**	**Plan for management:**
	Mild ☐ Yes ☐ No Severe ☐ Yes ☐ No	

*** For an Allergy, please complete the Child Care Emergency Plan for Allergic Reactions.**

Health Care Provider Name _____

Health Care Provider Signature _____Date_____

Mailing Address (Print) Phone _____

_____

_____

Please return to the child care program at the address listed below:

_____

Certificate of Immunization Status (CIS)

Washington State Department of Health

Reviewed by:	Date:
Signed COE on File? ☐ Yes ☐ No	

Please print. See back for instructions on how to fill out this form or get it printed from the Washington State Immunization Information System.

Child's Last Name:	First Name:	Middle Initial:	Birthdate (MM/DD/YYYY):

I give permission to my child's school/child care to add immunization information into the Immunization Information System to help the school maintain my child's record.	Conditional Status Only: I acknowledge that my child is entering school/child care in conditional status. For my child to remain in school, I must provide required documentation of immunization by established deadlines. See back for guidance on conditional status.
X _____ Parent/Guardian Signature Date	X _____ Parent/Guardian Signature Required if Starting in Conditional Status Date

▲Required for School ● Required Child Care/Preschool	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY
Required Vaccines for School or Child Care Entry						
●▲ DTaP (Diphtheria, Tetanus, Pertussis)						
▲ Tdap (Tetanus, Diphtheria, Pertussis) [illegible]						
●▲ DT or Td (Tetanus, Diphtheria)						
●▲ Hepatitis B						
● Hib (*Haemophilus influenzae type b*)						
●▲ IPV (Polio) (any combination of IPV/OPV)						
●▲ OPV (Polio)						
●▲ MMR (Measles, Mumps, Rubella)						
● PCV/PPSV (Pneumococcal)						
●▲ Varicella (Chickenpox) ☐ History of disease verified by IIS						
Recommended Vaccines (Not Required for School or Child Care Entry)						
Flu (Influenza)						
Hepatitis A						
HPV (Human Papillomavirus)						
MCV/MPSV (Meningococcal Disease types A, C, W, Y)						
MenB (Meningococcal Disease type B)						
Rotavirus						

Documentation of Disease Immunity (Health care provider use only)

If the child named in this CIS has a history of varicella (chickenpox) disease or can show immunity by blood test (titer), it must be verified by a health care provider.

I certify that the child named on this CIS has:
☐ A verified history of varicella (chickenpox) disease.
☐ Laboratory evidence of immunity (titer) to disease(s) marked below.

☐ Diphtheria	☐ Hepatitis A	☐ Hepatitis B
☐ Hib	☐ Measles	☐ Mumps
☐ Rubella	☐ Tetanus	☐ Varicella

☐ Polio (all 3 serotypes must show immunity)

▶

Licensed Health Care Provider Signature Date

▶

Printed Name

I certify that the information provided on this form is correct and verifiable.	Health Care Provider or School Official Name: _____ Signature: _____ Date: _____ If verified by school or child care staff the medical immunization records must be attached to this document.

Rainbow River Childcare LLC

Key Points

- **The Laws of the state of Washington require providers including Rainbow River to report any suspected child abuse or neglect.**
- Child will attend child care only during the scheduled days and times which will not exceed ten (10) hours a day.
- Monthly Charges are due on the first day of each Month for the month. Late fees will be assessed at **5%** per month. We are not responsible for collector's fees.
- Daycare closes at 5:30 pm. Parents who pick up their child after 5:30 pm. will be charged a late fee of **$2.00 per minute**, per child, which will be applied to next month's bill. (No Exceptions)
- Parents are required to sign their children in and out of the Daycare using their full legal signature.
- Make sure your child has an extra set of clothes (pants, shirt, underpants, and socks) at the daycare in case your child has an accident.
- Please do not allow your child to bring food, gum, or toys to school.
- State laws require that all children attending Rainbow River have current immunizations. Records will be kept on file at the daycare, parents are required to keep these records updated each time the child receives immunizations.
- Please keep child home when he/she has the following symptoms: Diarrhea, Vomiting, Coughing or a temperature of 99 degrees Fahrenheit, or other contagious illness, such as pinkeye, strep throat or chicken pox.
- If child is going to be absent, please call us. After 5 absent days without notice your children will be terminated.
- To assure that medicines are given properly each medicine must be in the original container and labeled with the child's name, date, doctor's name, the medication's name and the dose and directions for use, accompanied by a signed permission slip from the parent. We prefer not having to administer medication.
- Each day, the children eat Breakfast (8:30am), lunch (11:00pm Waddlers / 12:00pm Prek+Preschool), afternoon snack (3:00pm) and a late snack (5:00pm)
- We have a few basic rules and limits. No hurting others or ourselves physically or emotionally, and no destroying property.
- We do not use physical discipline. For severe discipline problems the child will be immediately removed from the other children and the parent will be called to pick up the child as soon as possible.
- Children are usually with their age group; however, there are times when your child may be grouped with a different age group/classroom.
- You know your child best! Let us know what is going on with your child (accidents, toilet training, a bad night's sleep, etc.). We will keep you informed about your child's day at the daycare.
- Please be reminded we have an open-door policy, parents are welcome anytime.
- We do take pictures/video of the children and share those pictures through our Lillio app, our website, Facebook, and CECI. Please us know in **writing if you do not** want us to share pictures/video of your child.
- Parent handbook which includes Rainbow River's daycare's policies, health policy, pesticide policy, pet policy, grouping policy and disaster plan can be found on our website.
- **Children must be dropped off no later than 9am. If your child will be late a phone call, email, or a message through Lillio must be received before 9am.**

Any questions or concerns feel free to call or text **Patty** Monday through Friday 6:30-6:00 **(509)551-7144 or Rainbow River (509)792-1149**

Child's Name_____ Date_____

Parent Signature_____

Rainbow River Childcare LLC

Consent Form

Child's Name: _____

Transportation Consent

I, (the natural parent or legal guardian) hereby give my permission for Rainbow River employees to transport my child by car or van to/from Rainbow River. All the children will be in appropriate child restraint system at all times. No child will share a constraint system with another child at anytime.

I will not hold Rainbow River, its director or employees liable in the event of an accident and/or injury.

Consent to Medical Care and Treatment of Minor Children

I,(the natural parent or legal guardian) herby give permission that my child may be given emergency treatment to include first aid and CPR by a qualified child care staff member at Rainbow River, I further authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by my child's regular physician, or when that physician cannot be reached, by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health and I cannot be contacted. I waive my right of informed consent to such treatment.

I also give permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

I certify (or declare) under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct:

Parent's Signature: _____ Date: _____

Non-medical Permission Form

Please note: We ask that you apply necessary topical lotions at home **before** school. We prefer not to apply anything at school due to various sensitivities and allergies. Although Rainbow River is willing to do so, as needed. Any lotion must be brought from home and labeled with child's full name.

I hereby give Rainbow River staff permission to use the following on my child,_____, to apply a sunscreen product of SPF-15 or higher to my child, as specified below, when they will be playing outside, especially during the months of march through October and between the daily times of 9:00am and 4:00pm. I understand that sunscreen may be applied to exposed skin including but not limited to the face, tops of ears, nose, bare shoulders, arms and legs. I have checked all applicable information regarding the type and use of sun screen for my child:

☐ I do not know of any allergies my child has to sunscreen & Rainbow River staff may use the sunscreen at the center following the directions printed on the bottle.

☐ My child is allergic to some sunscreen and/or I prefer to provide my own child with a sunscreen (no aerosols):

_____

☐ For medical or other reasons please do not apply sunscreen to my child or following areas:

_____

_____

_____

Check mark and/or add any lip balm/lotion that Rainbow River staff is allowed to apply to your child **IF necessary**. Leave blank if none required:

_____ Lip Balm:_____

_____ Hand Lotion:_____

Parent Name:_____ Date:_____

Parent Signature:_____

Participation Agreement

Participation Agreement to email and publish my child's work, photographs or videos via HiMama

To: Parent / Legal Guardian,

Please read this page carefully as it includes information about safety and security issues associated with privacy and behavior. In the interest of safety and security we require parent permission for the publishing of children's work, photographs or videos through a software program called HiMama (the "Program"). By signing this form you grant permission for us to photograph or video your child for the purposes of sharing this information with you through the Program. You will also receive updates and information about your child through the Program to the email you have provided herein. Note that sometimes other children in the center may feature in photos, videos or stories of your child. By giving your consent you agree not to share photos or video of any child, other than your own, outside the Program without permission. To learn more about the Program, please visit www.himama.com. Please complete, sign, and return this form to the center if you wish to participate. We encourage you to contact us if you have any questions. I hereby acknowledge that I wish to voluntarily participate in the Program:

_____

CHILD'S NAME

_____

PARENT/GUARDIAN NAME

_____

EMAIL

_____

PARENT/GUARDIAN SIGNATURE

_____

DATE

Development Screening Consent Form

Development screenings can identify a child's strengths as well as needs. Your participation in the developmental Screening program means you will complete screenings throughout the year about your child's overall development skills using a completed Ages & Stages Questionnaires (ASQ-3 & ASQ:SE). Your child's screening information will only be shared with you and his/her Early Learning Provider. The screening information cannot be released to other persons, programs or schools without your permission. You will have access to all information collected about your child at any time.

By giving consent you:

- Freely agree to participate in the developmental screening program using Ages & Stages Questionnaires (ASQ-3 & ASQ:SE).
- Can change your mind about participating in the developmental screening program at any time.

Please initial one of the two options:

_____ I give consent for my child_____, to participate in
(name of child)
the developmental screening.

_____ I do not give consent for my child_____, to
(name of child)
participate in the developmental screening.

Parent/guardian name:_____ Date:_____

Parent/guardian signature:_____ Date:_____

WASHINGTON
EARLY ACHIEVERS
PREPARING CHILDREN FOR SUCCESS IN SCHOOL

Infant-Toddler Consultation: FIND Participation Parent Consent

Dear Families,

Your childcare provider has volunteered to participate in infant-toddler consultation services provided by _____ (name of agency). This is a program that includes a video coaching element for teachers to help them learn to practice ways to encourage child development, called Filming Interactions to Nurture Development (FIND). FIND is made possible through a partnership with the University of Oregon (UO) as well as Children's Home Society of Washington (CHSW). Your child care provider is eligible to participate in FIND because they are a part of Early Achievers, our state's Quality Rating and Improvement System, which is funded by the Department of Early Learning.

Your child care provider will receive professional consultation with a FIND coach in the following areas:

- Sharing the child's focus
- Providing support and encouragement to the child
- Naming objects or describing activities
- Interacting back and forth with the child
- Starting and stopping activities with the child's interest

The video coaching program will be conducted over several weeks and will involve meeting with a FIND coach. In the first step of the program, the FIND coach will take a video recording of a teacher interacting in a classroom with one or several children doing regular activities of the day such as playing or eating. In the second step, the film will be sent electronically through a secure method to a film editor at CHSW. For training purposes, the film may also by reviewed by CHSW FIND consultants and members of the FIND development team at UO. The third step will involve the FIND coach showing the teacher very short clips of the video recording to show key moments when the teacher is supporting the children's development. In this session, the teacher will have a chance to discuss the video with the FIND coach and may be asked to complete practice assignments before the next video session.

All of your child's personal data will be kept confidential. Films will only be reviewed by FIND coaches, the CHSW FIND staff and the FIND development team at UO. No one outside the project will have access to records identifying participants' names at any time. To ensure confidentiality, all information will be coded so that it cannot be connected with any individual or family. Video clips will be uploaded to a secure server for the purposes of data collection and analysis and will be destroyed once all the data have been collected and analyzed.

The video recordings will only be labeled with an identification number (children's names are not shared) and will be uploaded to a secure server. CHSW staff will not have access to any personal

information about your child. The FIND development team at UO, CHSW FIND staff and FIND coaches have been trained in confidentiality protection and are required to sign confidentiality agreements.

Parent Consent to Video Recording

Please initial each authorized activity and sign below.

_____ I give consent for my child to be recorded on video during participation in the project and for those recordings to be viewed by the FIND coach, CHSW FIND staff and the FIND development team at UO.

_____ I understand that copies of the video recordings will be shared with CHSW FIND staff and the FIND development team at UO.

If you have any questions about this project, please contact _____(coach) at_____(email or phone)

I have received an adequate description of the purpose and procedures for the video recording included as part of this project and that any questions that arise during the course of the project will be answered. It has been satisfactorily explained to me that all information will be kept confidential and no identifying information will be included on the video recordings. It has also been satisfactorily explained to me that the video recordings will be erased after all the data have been collected and analyzed. I understand that my child's participation in the project is voluntary, that I am free to discontinue participation at any time, and that my decision to allow or not allow my child to participate in this project will not affect the services I receive from my child care provider or from the State of Washington.

Please check one: I am this child's :

☐ biological parent ☐ foster parent ☐ adoptive parent

_____ _____

Parent Signature Date

_____

Parent Name (please print)

_____

Participating Child's Full Name (please print)

_____ _____

Center Director/Family Home Child Care Owner Signature Date

_____

FIND Coach Name (please print)

OPT OUT: Initial below

_____ I do not give consent for my child to participate in FIND video recording

Diaper Cream/Ointment Application Record

(Must be filled out by the person who applies the cream/ointment)

Child's Name:

Name of Medication:

Date	Time	Initials	Date	Time	Initials	Date	Time	Initials	Date	Time	Initials

List any **side effects** and date below. Notify parent/guardian immediately.

Signatures (& initials) of persons applying cream/ointment:

_____ ( )

_____ ( )

_____ ( )

_____ ( )

_____ ( )

_____ ( )