

Admission Date:

Termination Date:

Child's Name: _____		Child's Address: _____	
DOB: _____		Your Relationship to Child: _____	
Your Relationship to Child: _____		Parent/Guardian Name: _____	
Parent/Guardian Name: _____		SSN: _____	
SSN: _____		Address: _____	
Address: _____		Homephone #: _____	
Homephone #: _____		Cellphone #: _____	
Cellphone #: _____		Work #: _____	
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					Welfare, Alimony, Child Support					Retirement, Pensions, Social Security, Other				
		Weekly	Every 2 Weeks	2X Monthly	Monthly		Weekly	Every 2 Weeks	2X Monthly	Monthly		Weekly	Every 2 Weeks	2X Monthly	Monthly
1.	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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- <input type="checkbox"/> Check if no SSN
Address _____	City/State/Zip Code _____	Daytime Phone _____

PART 6 -- CHILDREN'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care.

Ethnicity (check one): Hispanic or Latino Not Hispanic or Latino

Race (check one or more): American Indian or Alaskan Native Asian Black or African American Multi-Racial
 Native Hawaiian or Pacific Islander White

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, the funds your child care center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Basic Food, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine the meal reimbursement for your child care center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

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

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

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

MAIL*: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or

FAX: (833) 256-1665 or (202) 690-7442; or
EMAIL: program.intake@usda.gov

***Only use this address if you are filing a complaint of discrimination.**

This institution is an equal opportunity provider.

DO NOT FILL OUT - CENTER USE ONLY

- Child(ren) are categorically free based on Basic Food/TANF/FDPIR.
- Foster child(ren) have been identified on this form and qualify for the free category.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

Child(ren) on this form who are not categorically eligible qualify as follows:

- Check one:
- Free
 - Reduced-Price
 - Above-Scale

Total Income: \$ _____

- Annual Monthly Twice Per Month
- Every Two Weeks Weekly

X _____
Signature of Institution's Representative

Today's Date

NOT VALID WITHOUT SIGNATURE AND DATE.

EIEA Effective Date: If the institution is using the parent/guardian signature date as the effective date, the form must have been signed by the institution representative within the same month the parent signed the form or the immediately following month. If the institution representative does not evaluate and sign the EIEA within these guidelines, the institution representative's signature date must be used as the effective date.

CACFP Infant Meal Form

Infant Name:	Date of Birth:	Enrollment Start Date:
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Formula Information

Center Offers: Similac Advance Formula Type: Iron Fortified Infant Formula

Infant Formula Section Option:

ACCEPT or DECLINE (circle option) the center's formula. If declined, please document what the parent/guardian will provide for infant meals/feeding.

Breast milk Infant Formula _____ (specify brand)

Parent/Guardian Signature Date

Requirements

- Centers must offer at least one type of iron-fortified infant formula (IFIF) and required foods for the infant meal pattern.
- Parent/guardians may choose to:
 - Decline offered formula and supply a different formula or breast milk, expressed or by breastfeeding, on-site.
 - Provide their own foods in place of center-provided foods.
 - Parents/guardians cannot be required to provide infant formula or foods.

Form Instructions

- Complete this form for each infant and update as needed.
- Indicate the Type of formula that the center provides for infants.
- Keep this form on file to support the monthly claim.
- Check the appropriate boxes in the Components Offered section for items the parent supplies.
- Check the appropriate box in the Components Offered section when the infant is developmentally ready for a component.
- Record and date changes and updates in the Notes section when a new component is started, or changes are made (i.e. infant switches from breastmilk to a center provided IFIF).

Components Offered

Meal Components	Developmentally Ready	Parent Supplies	Changes/Updates	Date	Staff Initials
Breast Milk					
IFIF					
Iron-Fortified Infant Cereal					
Meat/Meat Alternate					
Fruit/Vegetable					
Grains					

Notes:

Reminders

- Only 2 meals and 1 snack **or** 1 meal and 2 snacks can be claimed per infant, per day.
- Record a meal or snack when:
 - Center supplies all components
 - Parent/guardian supplies only one (1) component.
 - Expressed breast milk is a component.
 - Parent supplies breast milk or IFIF and center provides all other foods.
- Do not record a meal or snack when:
 - Parent/guardian supplies **more than** one component
 - Center supplies infant cereal and parent supplies breast milk and fruits
 - Center supplies formula and parent supplies all other foods

CACFP Infant Meal Pattern
Breakfast, Lunch, Supper

Component	Birth – 5 Months	6 – 11 Months
Breastmilk or Infant Formula	4–6 fl. oz. breastmilk or formula	6–8 fl. oz. breastmilk or formula
Grains or Meat/Meat Alternates, or a combination	(not required)	<ul style="list-style-type: none"> • 0—½ oz eq (0–4 Tbsp) infant cereal; • or 0–4 Tbsp meat, fish, poultry, whole eggs, cooked dry beans or peas; • or 0–2 oz. cheese; • or 0–4 oz. cottage cheese; • or 0–4 oz. (½ cup) yogurt; • or a combination of the above
Vegetables, Fruit, or both	(not required)	0–2 Tbsp vegetables, fruit, or both

Snacks

Component	Birth – 5 Months	6 – 11 Months
Breastmilk or Infant Formula	4–6 fl. oz. breastmilk or formula	2–4 fl. oz. breastmilk or formula
Grains	(not required)	<ul style="list-style-type: none"> • 0—½ oz eq bread; • or 0—¼ oz eq crackers; • or 0—½ oz eq (0–4 Tbsp) infant cereal; • or 0—¼ oz eq ready-to-eat cereal
Vegetables, Fruit, or both	(not required)	0–2 Tbsp vegetables, fruit, or both

Abbreviations: fl. oz. = fluid ounces oz eq = ounce equivalent Tbsp = tablespoons



Certificate of Immunization Status (CIS)

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. X

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 _____ Parent/Guardian Signature Required if Starting in Conditional Status _____ Date _____

Required for School	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY
Required Child Care/Preschool					

Required Vaccines for School or Child Care Entry	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY
<ul style="list-style-type: none"> DTaP (Diphtheria, Tetanus, Pertussis) Tdap (Tetanus, Diphtheria, Pertussis) <small>(ages 11-12)</small> DT or Td (Tetanus, Diphtheria) Hepatitis B Hib (<i>Haemophilus influenzae type b</i>) IPV (Polio) <small>(any one of IPV or OPV)</small> OPV (Polio) MMR (Measles, Mumps, Rubella) PCV/PPSV (Pneumococcal) <small>(any one of PCV or PPSV)</small> Varicella (Chickenpox) History of disease verified by IIS 					

This form needs to be printed out by your child's doctor or printed out from myimmobile.com

Recommended Vaccines	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY
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 licensed/registered by:

<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Hepatitis B
<input type="checkbox"/> Hib	<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps
<input type="checkbox"/> Rubella	<input type="checkbox"/> Tetanus	<input type="checkbox"/> 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: _____



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 be 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:

_____ ()	_____ ()
_____ ()	_____ ()
_____ ()	_____ ()