KAFI FAMILY CHILDCARE

Daily Child Attendance Record for Child Care Facilities

Shaded section for child care staff use when child leaves and returns to licensee's care								Month and Year	
Date	**Child's Name (First/Last)**	**Time in**	**Parent/guardian or authorized person signature**	**Time out**	**Staff signature**	**Time in**	**Staff signature**	**Time out**	**Parent/guardian or authorized person signature**

KAFI FAMILY CHILDCARE

Family Home Child Care
Off-Site Permission Authorization for Occasional Trips

Off-site activities—Parent or guardian permission		
1) The licensee must: (a) Have written permission from the parent or guardian prior to the child engaging in off-site activities. The written permission must be kept in the child's file. (b) Have a separate permission for activities that occur less often than once per calendar month.		
Child's name First Middle Last	Licensee's Name	
A special outing is planned to:	Address:	
Date:	Departure Time:	Return Time:
The children will be transported by motor vehicle: Yes ☐ No ☐	We will be going on this outing using public transportation: Yes ☐ No ☐	
Notes:		
Please return this permission slip by:		
I give permission for my child Child's name:	To attend the outing to:	
Parent or guardian signature	Date	
This permission is granted when the licensee follows all the requirements for transporting children.		
In case of an emergency, I give permission for my child to receive medical treatment. In case of such an emergency, please contact:		
Name	Phone Number ( ) -	
Parent or guardian signature	Date	

Copies to parent or guardian and licensee

KAFI FAMILY CHILDCARE

Photo, video, or surveillance activity

I give my permission for the licensee or the licensee's staff to:

	Yes	No
Take photographs of my child.....	☐	☐
Take video of my child	☐	☐
Capture my child's image on surveillance video used at this child care facility	☐	☐

Food cooked by another child's parent or guardian (on special occasions only)

I give my permission for the licensee or the licensee's staff to:

	Yes	No
Serve my child food prepared, cooked or backed at home by another child's parent or guardian (on special occasions only).....	☐	☐

I have reviewed the licensee's written policies and have had the opportunity to discuss with the licensee the policies pertaining to the items listed on this permission form.

_____ _____

Parent or guardian signature Date

_____ _____

Parent or guardian signature Date

KAFI FAMILY CHILDCARE

Child Care Parent/Guardian Permission

Child's Name (First Middle Last)	Licensee's Name

Transportation and off-site activity

I give my permission for the licensee or the licensee's staff to take my child:

	Yes	No
To and/or from school:		
By a personal vehicle	☐	☐
By riding with my child on public transportation	☐	☐
By walking with my child	☐	☐
On field trips (a written notice about the field trip will be given at least 24 hours before the field trip is taken):		
By a personal vehicle	☐	☐
By riding with my child on public transportation	☐	☐
By walking with my child	☐	☐
On occasional errands:		
By a personal vehicle	☐	☐
By riding with my child on public transportation	☐	☐
By walking with my child	☐	☐
Other (specify here: _____):		
By a personal vehicle	☐	☐
By riding with my child on public transportation	☐	☐
By walking with my child	☐	☐

Water activities including swimming pools and other bodies of water

I give my permission for the licensee or the licensee's staff to:

	Yes	No
Take my child swimming or play in a swimming pool or other body of water	☐	☐

Bathing

I give my permission for the licensee or the licensee's staff to:

	Yes	No
Give my child a bath or shower if my child needs to be cleaned after having an accident such as diarrhea or vomiting	☐	☐
Give my child a bath or shower if my child is enrolled in overnight child care	☐	☐

KAFI FAMILY CHILDCARE

Child Care Medication Log

Child's Name (first and last):

Name of Medication (as it is appears on medication container):

**** If a medication was not given, you must document the reason why. ****

Date	Time	Dosage	Side Effects Observed (if any)

Name of person who gave medication: ______________________ ______________________
(print name) *(signature)*

Date	Time	Dosage	Side Effects Observed (if any)

Name of person who gave medication: ______________________ ______________________
(print name) *(signature)*

Date	Time	Dosage	Side Effects Observed (if any)

Name of person who gave medication: ______________________ ______________________
(print name) *(signature)*

Date	Time	Dosage	Side Effects Observed (if any)

Name of person who gave medication: ______________________ ______________________
(print name) *(signature)*

Date	Time	Dosage	Side Effects Observed (if any)

Name of person who gave medication: ______________________ ______________________
(print name) *(signature)*

Date	Time	Dosage	Side Effects Observed (if any)

Name of person who gave medication: ______________________ ______________________
(print name) *(signature)*

Date	Time	Dosage	Side Effects Observed (if any)

Name of person who gave medication: ______________________ ______________________
(print name) *(signature)*

Date	Time	Dosage	Side Effects Observed (if any)

Name of person who gave medication: ______________________ ______________________
(print name) *(signature)*

KAFI FAMILY CHILDCARE

Child Care Medication Authorization Form

An early learning provider must not give medication to any child without written and signed consent from that child's parent or guardian, must administer medication pursuant to directions on the medication label, and must use appropriate cleaned and sanitized medication measuring devices. WAC 110-300-0215

Child's full name (first and last):		Child's Birthdate:
Name of Medication (as it appears on medication container):		
Dosage:	Start Date:	End Date:
To be given at the following times:		
Reason for Giving Medication to Child/Medical Need:		
Possible Side Effects of Medication:		
Additional Information:		

Prescription medication must only be given to the child named on the prescription. Prescription medication must be labeled with: child's first and last name, the date the prescription was filled, the name and contact information of the prescribing health professional, the expiration date, dosage amount, length of time to give the medication, and instructions for administration and storage.

Nonprescription (over-the-counter) medication must be brought to the early learning program by the child's parent or guardian in the original packaging with expiration date and labeled with the child's first and last name. It must only be given to the child named on the label provided by the parent or guardian. Instructions on the label must be followed, unless the parent or guardian provides a medical professional's note.

If the packaging label does not include expiration date, dosage amount, age, and length of time to give the medication, then written authorization from a health care provider with prescriptive authority is required, as well as the written and signed consent from the child's parent or guardian. This includes: vitamins, herbal supplements, fluoride supplements, homeopathic or naturopathic medication, and teething gels or tablets (amber bead necklaces are prohibited).

I hereby give permission for the staff of _____ *to give my child the medication as prescribed above.*
(name of early learning provider/program)

_____ _____
Parent/Guardian Signature *Date*

This section to be completed by child's parent or guardian, if applicable:
I, or my appointed designee, have provided training about specialized medication administration procedures for my child specific to this medication to the following staff member(s): _____

_____ _____
Parent/Guardian (or Designee) Signature *Date* *Early Learning Provider Signature* *Date*

Washington State Department of CHILDREN, YOUTH & FAMILIES

KAFI FAMILY CHILDCARE

Child Care Injury/Incident Report

Child's Name:

In addition to reporting to the department by phone or email about the following incidents and injuries, an early learning provider must also complete this incident report and submit it to DCYF within 24-hours.

Provider Name			Provider ID
Child's Age	Date of Incident	Time of Incident ☐ a.m. ☐ p.m.	Incident Occurred ☐ Indoors ☐ Outdoors
List names of staff present and/or witnesses:		Treatment provided to child while in care & by who:	

Check All That Apply

Situation that required an emergency response from:

☐ Emergency services (911) 110-300-0475(2)(b)
☐ Washington poison center 110-300-0475(2)(c)
☐ Department of Health 110-300-0475(2)(d)

Situations that occur while children are in care that may put children at risk including, but not limited to:

☐ Inappropriate sexual touching ☐ Physical abuse ☐ Neglect ☐ Maltreatment ☐ Exploitation
☐ Other

Serious injury to a child in care:

☐ Severe bleeding ☐ One or more broken bones ☐ Choking or serious unexpected breathing problems
☐ Severe neck/head injury ☐ Sudden unconsciousness ☐ Dangerous chemicals in eyes, on skin, or ingested
☐ Near drowning ☐ Shock or acute confused state ☐ Severe burn requiring professional medical care
☐ Poisoning ☐ Overdose of chemical substance ☐ Injury resulting in overnight hospital stay

Please give a brief description of the injury/incident, including where it occurred.

Parent/Guardian Contacted	Licensor Contacted
Date: Time: ☐ In Person ☐ Phone ☐ E-mail	Date: Time: ☐ In Person ☐ Phone ☐ E-mail

Parent/Guardian Comments:

Parent/Guardian Signature Date	Licensee/Staff Signature Date
By signing this form, I acknowledge that I received a copy of this report.	

Licensor - Complete before sending form to Licensing Analyst: Intake? ☐ No ☐ Yes Provider Case # _____

KAFI FAMILY CHILDCARE

Instructions for completing the Certificate of Immunization Status (CIS): printing it from the Immunization Information System (IIS) or filling it in by hand.

To print with immunization information filled in: Ask if your healthcare provider's office enters immunizations into the WA Immunization Information System (Washington's statewide database). If they do, ask them to print the CIS from the IIS and your child's immunization information will fill in automatically. You can also print a CIS at home by signing up and logging into MyIR at https://wa.myir.net. **If your provider doesn't use the IIS, email or call the Department of Health to get a copy of your child's CIS: waiisrecords@doh.wa.gov or 1-866-397-0337.**

To fill out the form by hand:

#1 Print your child's name, birthdate, sex, and sign your name where indicated on page one.

#2 Vaccine information: Write the date of each vaccine dose received in the date columns (as MM/DD/YY). If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guides below to record each vaccine correctly. For example, record Pediarix under Diphtheria, Tetanus, Pertussis as **DTaP**, Hepatitis B as **Hep B**, and Polio as **IPV**.

#3 History of Varicella Disease: If your child had chickenpox (varicella) disease and not the vaccine, **a health care provider must verify chickenpox disease to meet school requirements.**

- ☐ If your healthcare provider can verify that your child had chickenpox, ask your provider to check the box in the Documentation of Disease Immunity section and sign the form.
- ☐ If school staff access the IIS and see verification that your child had chickenpox, they will check the box under Varicella in the vaccines section.

#4 Documentation of Disease Immunity: If your child can show positive immunity by blood test (titer) and has not had the vaccine, have your healthcare provider check the boxes for the appropriate disease in the Documentation of Disease Immunity box, and sign and date the form. **You must provide lab reports with this CIS.**

Reference guide for vaccine abbreviations in alphabetical order For updated list, visit https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf

Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus	Hep A	Hepatitis A	MCV / MCV4	Meningococcal Conjugate Vaccine	OPV	Oral Poliovirus Vaccine	Tdap	Tetanus, Diphtheria, acellular Pertussis
DTaP	Diphtheria, Tetanus, acellular Pertussis	Hep B	Hepatitis B	MenB	Meningococcal B	PCV / PCV7 / PCV13	Pneumococcal Conjugate Vaccine	VAR / VZV	Varicella
DTP	Diphtheria, Tetanus, Pertussis	Hib	*Haemophilus influenzae* type b	MPSV / MPSV4	Meningococcal Polysaccharide Vaccine	PPSV / PPV23	Pneumococcal Polysaccharide Vaccine		
Flu (IIV)	Influenza	HPV (2vHPV / 4vHPV / 9vHPV)	Human Papillomavirus	MMR	Measles, Mumps, Rubella	Rota (RV1 / RV5)	Rotavirus		
HBIG	Hepatitis B Immune Globulin	IPV	Inactivated Poliovirus Vaccine	MMRV	Measles, Mumps, Rubella with Varicella	Td	Tetanus, Diphtheria		

Reference guide for vaccine trade names in alphabetical order For updated list, visit https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB®	Hib	Fluarix®	Flu	Havrix®	Hep A	Menveo®	Meningococcal	Rotarix®	Rotavirus (RV1)
Adacel®	Tdap	Flucelvax®	Flu	Hiberix®	Hib	Pediarix®	DTaP + Hep B + IPV	RotaTeq®	Rotavirus (RV5)
Afluria®	Flu	FluLaval®	Flu	HibTITER®	Hib	PedvaxHIB®	Hib	Tenivac®	Td
Bexsero®	MenB	FluMist®	Flu	Ipol®	IPV	Pentacel®	DTaP + Hib + IPV	Trumenba®	MenB
Boostrix®	Tdap	Fluvirin®	Flu	Infanrix®	DTaP	Pneumovax®	PPSV	Twinrix®	Hep A + Hep B
Cervarix®	2vHPV	Fluzone®	Flu	Kinrix®	DTaP + IPV	Prevnar®	PCV	Vaqta®	Hep A
Daptacel®	DTaP	Gardasil®	4vHPV	Menactra®	MCV or MCV4	ProQuad®	MMR + Varicella	Varivax®	Varicella
Engerix-B®	Hep B	Gardasil® 9	9vHPV	Menomune®	MPSV4	Recombivax HB®	Hep B		

If you have a disability and need this document in another format, please call 1-800-525-0127 (TDD/TTY call 711).

KAFI FAMILY CHILDCARE

Health

Certificate of Immunization Status (CIS)

For Kindergarten-12th Grade / Child Care Entry

Office Use Only:	
Reviewed by:	Date:
Signed Cert. of Exemption on file? ☐ Yes ☐ No	

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

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

I give permission to my child's school to share immunization information with the Immunization Information System to help the school maintain my child's school record.

Parent/Guardian Signature Required **Date**

I certify that the information provided on this form is correct and verifiable.

Parent/Guardian Signature Required **Date**

♦ Required for School and Child Care/Preschool
● Required Only for 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 / DT** (Diphtheria, Tetanus, Pertussis)						
♦ **Tdap** (Tetanus, Diphtheria, Pertussis)						
♦ **Td** (Tetanus, Diphtheria)						
♦ **Hepatitis B** ☐ 2-dose schedule used between ages 11-15						
● **Hib** (*Haemophilus influenzae* type b)						
♦ **IPV / 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)						
MenB (Meningococcal)						
Rotavirus						

Documentation of Disease Immunity

Healthcare provider use only

If the child named in this CIS has a history of Varicella (Chickenpox) or can show immunity by blood test (titer) it MUST be verified by a healthcare provider

I certify that the child named on this CIS has:

☐ a verified history of Varicella (Chickenpox).

☐ laboratory evidence of immunity (titer) to disease(s) marked below. **Lab report(s) for titers MUST also be attached.**

☐ Diphtheria	☐ Mumps	☐ Other:
☐ Hepatitis A	☐ Polio	
☐ Hepatitis B	☐ Rubella	
☐ Hib	☐ Tetanus	
☐ Measles	☐ Varicella	

Licensed healthcare provider signature (MD, DO, ND, PA, ARNP) Date

Printed Name

KAFI FAMILLY CHILDCARE

Child Care Agreement

	First	Middle	Last
Child's name:			
Parent or guardian name:			
Parent or guardian name:			

Days and times my child will receive care:

Check days of care	☐ Sunday	☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday	☐ Saturday
Arrival time							
Departure time							

Fee: $ per:

☐ Hour ☐ Day ☐ Week ☐ Month

Date payment due:

Source of payment: ☐ Parent ☐ Other (specify):

Overtime rate: $ per

Late fee: $ per

Other Fees: $ Description:

I agree to promptly notify the child care provider 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, understand and agree to comply with the policy and procedures and information for parents given to me by

_____

Name of licensee

Parent or guardian signature	Date	Parent or guardian signature	Date

I agree to provide child care services according to the above plan. I agree to promptly notify the parents or guardians of any changes to above information.

Licensee signature Date

Street address	City	State	Zip code

Comments

KAFI FAMILY CHILDCARE

I give permission that my child, _____ may be given first aid/emergency treatment by the child care licensee and or qualified staff at:

Name of Licensee: _____

Address of Licensee: _____

Parent/guardian signature	Date	Parent/guardian signature	Date

When I cannot be contacted, I authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital or aid car attendant when deemed necessary or advisable by the physician or aid care attendant to safeguard my child's health. I waive my right of informed consent to such treatment.

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

I certify under penalty of perjury under the laws of the State of Washington that this information is true and correct.

Parent/guardian signature	Date	Parent/guardian signature	Date

KAFI FAMILY CHILDCARE

Child Care Registration Form **(for family home or center program)**	Date child entered care	Date child left care

Child's name (Last, First, Middle)	Name used (Nickname)	Birthdate
Street address	City	Zip code

Child's parent/guardian name	Circle the best number to contact you at when your child is in our care		
	cell phone #	home phone #	alternate phone #
	( ) -	( ) -	( ) -
Street address	City		Zip code

Child's parent/guardian name	Circle the best number to contact you at when your child is in our care		
	cell phone #	home phone #	alternate phone #
	( ) -	( ) -	( ) -

I give my permission for any of the following individuals to be contacted and my child may be released to any of them.

Parent/Guardian signature: _____ *Date:* _____

In an emergency, if you are not able to contact me, contact the following:

Name (first and last)	cell phone #	home phone #	alternative phone #
	( ) -	( ) -	( ) -
	( ) -	( ) -	( ) -
	( ) -	( ) -	( ) -
	( ) -	( ) -	( ) -

These individuals also have permission to pick up my child:

Name (first and last)	cell phone #	home phone #	alternative phone #
	( ) -	( ) -	( ) -
	( ) -	( ) -	( ) -
	( ) -	( ) -	( ) -
	( ) -	( ) -	( ) -

Child's health information

Child's medical care provider or parent's/guardian's preferred medical facility for treatment Name: Phone: ( ) - Street Address:	Child's last physical exam, if available
Child's dental care provider or parent's/guardian's preferred dental facility for treatment Name: Phone: ( ) - Street Address:	Child's last dental exam, if available

Known health conditions (An individual care plan from child's health care provider is required for any food allergies or special dietary requirement due to a health condition.)

Consent to medical care and treatment of minor children