Bella Mente Enrollment Paperwork

2023-2024

Director: Lauren Adams
206-321-6448
Bellamenteearlylearning@gmail.com

Please fill out and complete all forms for EACH child for the 2023/2024 school year. Thanks!

Child Care Registration and Agreement Form

Child

Name:_____ Birthday:_____

Physical Address:_____

Mailing address (if different than physical)_____

Parent/Guardian

Name:_____ Number:_____ Email:_____

Name:_____ Number:_____ Email:_____

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

Name:_____ Number:_____ Email:_____

Name:_____ Number:_____ Email:_____

If someone is picking up who is not on this list, please notify Lauren via text or email with their name, and let them know they will be asked to show ID. 206-321-6448 or bellamenteearlylearning@gmail.com

In case of emergency, I give permission for any of the above individuals to be contacted and my child may be released to any of them.

Parent/ Guardian Signature_____Date_____

Attendance and Tuition for the 2023/2024 School Year

Tuition is due on the first of the month. Part time tuition is prorated based on the monthly rates below. Families will be given a one-month notice of any increase. Bella Mente is open M-F from 7:30am-5:30pm

- Newcomer: $2050
- Acclimation/Independence: $1750
- Adventure/Discovery/Maven:$1650
- School-Age: $550

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 stipulated. I have read and understand and agree with the policy and procedures and information given to me by Bella Mente Early Learning.

Parent/ 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

Provider Signature:_____Date_____

Date Child Entered Care_____Date Child Left Care:_____

Staff Signature_____

Consent to Medical Care

Child's Name: _____ Child's Birthday_____

Allergies(including drug reactions):_____

Health problems or concerns: _____

Date of Last physical exam:_____

Child's Healthcare Provider: _____

Current Medications:_____

Insurance Company name: _____

Policy Holder Name:_____Policy Number:_____

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

Bella Mente Early Learning,

9051 20th ave SW Seattle, WA 98106

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, healthcare provider, hospital or aid car care attendant when deemed necessary or advisable by the physician or aid car attendant to safeguard my child's health. 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 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:_____

Parent Acknowledgement Letter

I acknowledge that I have read through the Bella Mente Parent handbook and understand the policies and procedures.

The handbook can be found at this link:

Bellamente.org/preschoolhandbook

_____

Child Name

_____	_____	_____
Parent or Guardian Signature	Date	Email (please print)
_____	_____	_____
Parent or Guardian Signature	Date	Email (please print)

What is your line of work? Would you be willing to share what you do with the children?

_____

_____

Is there anything you would like us to know about your child that you have not already included?

_____

_____

Sunscreen Permission Form

During summer months, I will apply sunscreen to my child before coming to school and allow Bella Mente to apply as needed with a personal or bulk sunscreen provided from home or Bella Mente.

_____

Child Name

_____ _____

Parent or Guardian Signature Date

Photo/ Video Permission Form

Photos and videos provide an incredible insight to our learning process here at Bella Mente. We use this as a way to document your child's creative process. It serves as a way for teachers to showcase how children got to where they are, it becomes a way for children to revisit their understandings and it provides a window into their day for the parents.

In signing this document, I grant Bella Mente Early Learning the right to take photographs of my child.

I agree that Bella Mente Early Learning may use such photos for any lawful purpose including, for example, classroom documentation, classroom Facebook pages, portfolios, learning resources in the classroom, teacher training, website content or advertising.

_____

Child Name

_____ _____

Parent or Guardian Signature Date

Walking Fleld Trip Form

In signing this document, I grant Bella Mente Early Learning staff the right to take my child on walking field trips from Bella Mente during normal business hours.

Walking Fleldtrips will:

- Never exceed 2 hours
- Be age appropriate for each of our classes
- A note will be placed on the door when the class leaves
- Staff will have First Aid Kits and phones for emergencies

This includes but is not limited to:

- The Garden lot next to our playground (We plan to use this Daily)
- Art Studio
- The walk between classrooms and the playgrounds
- Trash runs to the basement (may use elevator)
- Walks around the neighborhood

_____

Child Name

_____ _____

Parent or Guardian Signature Date

Bella Mente Transportation Permission Slip

****THIS IS FOR SCHOOL AGERS ONLY****

In signing this document, I grant Bella Mente Early Learning the right to transport my **SCHOOL AGE** child via van during normal business hours. This includes transportation from an approved School during Seattle public schools calendar year, and for any field trip during the child's enrollment at Bella Mente Early Learning.

Transportation will:

- Have appropriate seating/booster and seatbelt for each child
- Driver will be insured, passed a background check, and have a clean driving record
- The van will have First Aid Kits and phones for emergencies only

Bella Mente provides booster seats for our Van. Please select which best fits the need of your child:

☐ My child needs to use a booster seat in the van

☐ My child does not need to use a booster in the van

_____

Child Name

_____ _____

Parent or Guardian Signature Date

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

#1 To print with info filled in: First, ask if your health care provider's office puts vaccination history into the CHILD Profile Immunization Registry (Washington's statewide database). If they do, ask them to print the CIS from CHILD Profile and your child's information will fill in automatically. **Be sure** to review all the information, **sign and date the CIS** in the upper right hand box, and return it to school or child care. If your provider's office does not use CHILD Profile, ask for a copy of your child's vaccine record so you can fill it in by hand using steps #2-7 (below):

EXAMPLE

Vaccine	Dose	Date		
		Month	Day	Year
◆ **Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)**				
DTaP	1	01	12	2011
DTaP	2	03	20	2011
DTaP	3	06	01	2011

#2 To fill in by hand: Print your child's name, birthdate, sex, and your own name in the top box.

#3 Write each vaccine your child received under the correct disease. Write the vaccine type under the "Vaccine" column and the date each dose was received in the "Month," "Day," and "Year" columns (as mm/dd/yyyy). For example, if DTaP was received Jan 12, March 20, June 1, '11, fill in as shown here ▶

#4 If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guide 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**.

#5 If your child has had chickenpox (varicella) disease and not the vaccine, **use only one** of these four options to record this on the CIS:

1) ❑ If your child's CIS is printed directly from the CHILD Profile Immunization Registry (by your health care provider or school system), and disease verification is found, box 1 is automatically marked. To be valid, this box must be marked by the Immunization Registry printout (not by hand).
2) ❑ If your health care provider (HCP) can verify that your child has had chickenpox, mark box 2. Then mark either 2A to attach a signed note from your HCP, or 2B if your HCP signs and dates in the space provided. Be sure your HCP's full name is also printed.
3) ❑ If school staff access the CHILD Profile Immunization Registry and see verification that your child has had chickenpox, they will mark box 3. Then, they must initial and date that they got parent or guardian approval to mark this box (i.e. make this change) to the CIS.
4) ❑ If your child started kindergarten in the 2008-2009 school year or later, you **CANNOT** use this box. If your child started kindergarten before the 08-09 school year, mark this box if you know he or she has had chickenpox. If you mark box 4, you must also write the approximate age or date your child had chickenpox. To find out which grades require chickenpox vaccine (or history), visit: http://www.doh.wa.gov/cfh/immunize/schools/vaccine.htm

#6 Documentation of Disease Immunity: If your child can show immunity by blood test (titer) and has not had the vaccine, have your health care provider (HCP) fill in this box. Ask your HCP to mark the disease(s), sign, date, print his or her name in the space provided, and **attach signed lab reports**.

#7 Be sure to **sign and date the CIS** in the upper right hand box, and return to school or child care.

#8 If a school or child care makes a change to your CIS, staff will print their name in the middle bottom box and date to show that you gave approval.

Reference Guide

Vaccine Trade Names in alphabetical order (For updated lists, visit http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf)

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB	Hib	Engerix-B	Hep B	Ipol	IPV	Pentavalente	DTaP + Hep B + Hib	TriHIBit	DTaP + Hib
Adacel	Tdap	Fluarix	Flu (TIV)	Infanrix	DTaP	Pneumovax	PPSV or PPV23	Tripedia	DTaP
Afluria	Flu (TIV)	FluLaval	Flu (TIV)	Kinrix (Knrx)	DTaP + IPV	Prevnar	PCV or PCV7 or PCV13	Twinrix (Twnrx)	Hep A + Hep B
Boostrix	Tdap	FluMist	Flu (LAIV)	Menactra	MCV or MCV4	ProQuad (PrQd)	MMR + Varicella	Vaqta	Hep A
Cervarix	HPV2	Fluvirin	Flu (TIV)	Menomune	MPSV or MPSV4	Quadracel (Qdrcl)	DTaP + IPV	Varivax	Varicella
Comvax (Cmvx)	Hep B + Hib	Fluzone	Flu (TIV)	Pediarix (Pdrx)	DTaP + Hep B + IPV	Recombivax HB	Hep B		
Daptacel	DTaP	Gardasil	HPV4	PedvaxHIB	Hib	Rotarix	Rotavirus (RV1)		
Decavac	Td	Havrix	Hep A	Pentacel (Pntcl)	DTaP + Hib + IPV	RotaTeq	Rotavirus (RV5)		

Vaccine Abbreviations in alphabetical order (For updated lists, visit http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf)

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

If you have a disability and need this document in another format, please call 1-800-525-0127 (TDD/TTY 1-800-833-6388).

DOH 348-013 January 2010

A copy of your child immunizations from MYCHART or your doctor will work as well*

Certificate of Immunization Status (CIS)

DOH 348-013 January 2010

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 Immunization Registry.

Child's Last Name: **First Name:** **Middle Initial:** **Birthdate** (mm/dd/yyyy): **Sex:**

Symbols below: ◆ Required for School and Child Care/Preschool
● Required for Child Care/Preschool Only

Parent/Guardian Name (please print):

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

Parent/Guardian Signature Required **Date**

Vaccine	Dose	Date Month	Day	Year
◆ **Hepatitis B (Hep B)**				
	1			
	2			
	3			
or Hep B - 2 dose alternate schedule for teens				
	1			
	2			
Rotavirus (RV1, RV5)				
	1			
	2			
	3			
◆ **Diphtheria, Tetanus, Pertussis** (DTaP, DTP, DT)				
	1			
	2			
	3			
	4			
	5			
◆ **Tetanus, Diphtheria, Pertussis** (Tdap, Td)				
	1			
	2			
● ***Haemophilus influenzae* type b (Hib)**				
	1			
	2			
	3			
	4			
● **Pneumococcal (PCV, PPSV)**				
	1			
	2			
	3			
	4			

Vaccine	Dose	Date Month	Day	Year
◆ **Polio (IPV, OPV)**				
	1			
	2			
	3			
	4			
Influenza (flu, most recent)				
◆ **Measles, Mumps, Rubella (MMR)**				
	1			
	2			
◆ **Varicella (chickenpox)** or verify disease 1-4 ▶				
	1			
	2			
Hepatitis A (Hep A)				
	1			
	2			
Meningococcal (MCV, MPSV)				
	1			
Human Papillomavirus (HPV)				
	1			
	2			
	3			

Office Use Only: Immunization information updated and verified with parent/guardian permission:

Printed Staff Name Date	Printed Staff Name Date
Printed Staff Name Date	Printed Staff Name Date

If the child named on this CIS had chickenpox disease (and not the vaccine), disease history must be verified.
Mark option 1, 2, 3, OR 4 below – see, back #5.

1) ❑ Chickenpox disease verified by printout from CHILD Profile Immunization Registry
Must be marked by printout (not by hand) to be valid.

2) ❑ Chickenpox disease verified by Health Care Provider (HCP)
If you choose this box, mark 2A **OR** 2B below.
2A) ❑ Signed note from HCP attached **OR**
2B) ❑ HCP signed here and print name below:

Licensed health care provider (HCP) Signature **Date**
(MD, DO, ND, PA, ARNP)
HCP Printed Name: _____

3) ❑ Chickenpox disease verified by school staff from CHILD Profile Immunization Registry
If you choose this box, staff must initial that parent or guardian approves: _____(initial) _____(date)

4) ❑ Chickenpox disease verified by parent*
If you choose this box, fill in the date or child's age when he or she had the disease:
Age/Date of disease:_____
*Can **ONLY** verify for some grades, see back #5 (4).

If the child can show immunity by blood test (titer) and hasn't had the vaccine, ask your HCP to fill in this box.

Documentation of Disease Immunity

I certify that the child named on this CIS has laboratory evidence of immunity (titer) to the diseases marked.
Signed lab report(s) MUST also be attached.

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

Licensed health care provider (HCP) Signature **Date**
(MD, DO, ND, PA, ARNP)
HCP Printed Name: _____

A copy of your child immunizations from MYCHART or your doctor will work as well*

Washington State Department of Early Learning

Medication Permission Form

CHILD'S INFORMATION		
NAME OF CHILD	DATE OF BIRTH	TODAY'S DATE
NAME OF MEDICINE	DOSE	
TIME(S) TO GIVE MEDICINE		
DATE TO START MEDICINE	DATE TO STOP MEDICINE	
KNOWN SIDE EFFECTS TO MEDICINE		
ADDITIONAL INSTRUCTIONS		
HOW IS THIS MEDICINE GIVEN? (CIRLCE ONE) ☐ BY MOUTH ☐ IN THE EAR ☐ IN THE EYE ☐ NEBULIZER ☐ ON THE SKIN ☐ OTHER	CHILD ALLERGIES	

PRESCRIBER'S INFORMATION
PRESCRIBING HEALTH PROFESSIONAL'S NAME

PERMISSION TO GIVE MEDICINE		
I hereby give permission for the licensee to give the medication as prescribed above.		
PARENT OR GUARDIAN NAME (PRINT)		
PARENT OR GUARDIAN SIGNATURE	DATE	
ADDRESS		
HOME PHONE NUMBER ( ) -	CELL PHONE NUMBER ( ) -	ALTERNATIVE PHONE NUMBER ( ) -