

**If completing on your computer:** save this PDF *before* entering data and again when finished. Email, fax, or drop off completed packet.

Dr. Day Care Home Office:  
Phone: 401-475-7707      Fax: 401-231-5048      Email: [info@drdaycare.com](mailto:info@drdaycare.com)  
Mailing Address: 1201 Douglas Pike, Suite 4, Smithfield, RI 02917

Today's Date: \_\_\_\_\_

Start Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Site Name: \_\_\_\_\_

How did you hear about Dr. Day Care or Kids Klub?  
To whom may we thank for referring you to our program? \_\_\_\_\_

Enclosed you will find the necessary documents to register your child at Dr. Day Care Learning Center. Please complete this Enrollment Application in order to enroll your child in our program. In order to enroll your child in a Dr. Day Care Learning Center, please contact the Site Administrator regarding availability and scheduling.

**Required:**

- Completed Enrollment Packet
  - Registration Form
  - Emergency Consent
  - Parent Authorization
  - Parent Agreement Contract
  - Developmental History pages
    - Infant and Toddler, Preschool, or School Age
  - Meals Served Enrollment Form
  - Meal Benefit Form
- Physical and Immunization Records  
(updated annually and after every doctor visit)
- Registration Fee\*
- First Week's Tuition
- Family photo for classroom
- Confirmed start date with Site Administrator

Note: if your child is taking medication that needs to be administered during the center's hours, a parent must sign a Medication Permission Form accompanied with a prescription or written order.

**For your information:**

- Building for the Future
- Women, Infants, And Children (WIC)
- CACFP Meal Benefit Instructions & Letter to Parents
- Dr. Day Care Information

**\* \$5 of each child's Registration fee will be donated to Hasbro Children's Hospital**

*To Benefit*



**Hasbro Children's Hospital**  
The Pediatric Division of Rhode Island Hospital  
*Lifespan. Delivering health with care.*®

**If applicable:**

- DHS Child Care Subsidy
- DHS Absenteeism Form Letter
- Infant Meals

**Elementary School Attending:**

(for School Age students only)

**Current Grade:** \_\_\_\_\_

(indicate the grade child will be in, if enrolling in advance)



# Registration Form

## Child's Information

Child's Name \_\_\_\_\_  Female  Male Nickname \_\_\_\_\_  
(first, middle, last)  
Date of Birth \_\_\_\_\_ Child's Address,  
Town, State & Zip \_\_\_\_\_

## Child's Physical Description

Eye Color \_\_\_\_\_ Hair Color \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_  
Birthmarks \_\_\_\_\_ Racial/Ethnic Identity \_\_\_\_\_  
Additional Identifying Features \_\_\_\_\_

Administrator  
will attach a  
photo here  
from Procare

## Parents/Guardians

Parents/Guardians/Payers may receive financial statements and financial information on the account.  
Parents/Guardians/Payers and Emergency Contacts have permission to speak and sign off on information about the child's day.

Payer #1/Parent/Guardian \_\_\_\_\_  
Relationship to child \_\_\_\_\_  
Address \_\_\_\_\_  
Town, State & Zip \_\_\_\_\_  
Driver's License # \_\_\_\_\_  
Health Insurance Coverage Number \_\_\_\_\_  
Employed By \_\_\_\_\_  
Cell Phone # \_\_\_\_\_  
Business Telephone # \_\_\_\_\_  
Home Telephone # \_\_\_\_\_  
Email Address \_\_\_\_\_

Payer #2/Parent/Guardian \_\_\_\_\_  
Relationship to child \_\_\_\_\_  
Address \_\_\_\_\_  
Town, State & Zip \_\_\_\_\_  
Driver's License # \_\_\_\_\_  
Health Insurance Coverage Number \_\_\_\_\_  
Employed By \_\_\_\_\_  
Cell Phone # \_\_\_\_\_  
Business Telephone # \_\_\_\_\_  
Home Telephone # \_\_\_\_\_  
Email Address \_\_\_\_\_

## Emergency Contacts

Any updates to Emergency Contacts must be made in writing. Please see site Administrator for a Security Questions Form.

The following individual(s) may also pick up my child as needed for departure and/or emergencies. I understand that any individuals not listed will not be allowed to pick up unless I provide written permission in advance. Proper Photo ID is required for pick up of your child. All emergency contacts must be 18 years or older.

Name \_\_\_\_\_  
Relationship to child \_\_\_\_\_  
Preferred Phone # \_\_\_\_\_  
Address, Town, State & Zip \_\_\_\_\_  
Driver's License # \_\_\_\_\_  
Email Address \_\_\_\_\_

Name \_\_\_\_\_  
Relationship to child \_\_\_\_\_  
Preferred Phone # \_\_\_\_\_  
Address, Town, State & Zip \_\_\_\_\_  
Driver's License # \_\_\_\_\_  
Email Address \_\_\_\_\_

Name \_\_\_\_\_  
Relationship to child \_\_\_\_\_  
Preferred Phone # \_\_\_\_\_  
Address, Town, State & Zip \_\_\_\_\_  
Driver's License # \_\_\_\_\_  
Email Address \_\_\_\_\_

Name \_\_\_\_\_  
Relationship to child \_\_\_\_\_  
Preferred Phone # \_\_\_\_\_  
Address, Town, State & Zip \_\_\_\_\_  
Driver's License # \_\_\_\_\_  
Email Address \_\_\_\_\_

## Are there any circumstances regarding your child's release?

Yes  No

Any special instructions, such as custody or restraining orders must be attached to this application  
and discussed personally with the Administrator. All information will be kept confidential.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If applicable:

DCYF Primary Worker Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Emergency Consent

Child's Name \_\_\_\_\_  
(first, middle, last)

Date of Birth \_\_\_\_\_

I hereby authorize Dr. Day Care, Inc. to arrange for medical examination and/or treatment of my child should an emergency arise at school or on a field trip. It is understood that a conscientious effort will be made by the school to contact me at the emergency numbers I have provided before any medical action is taken. I would prefer to have my child, if the need arises, taken to (Hospital Name) \_\_\_\_\_. The choice of hospital may be limited by service or local rescue. I authorize Dr. Day Care to act as the agent of the parents in an emergency situation for the health and welfare of my child. I am responsible for the expenses involved if the services of a physician or hospital are required.

Child's Physician's Name \_\_\_\_\_

Physician's Address \_\_\_\_\_

Physician's Phone Number \_\_\_\_\_

Child's Chronic Health Conditions \_\_\_\_\_

Child's Medication and Dosage \_\_\_\_\_

*All medication to be administered at the Learning Center must be accompanied by a Medication Permission Form. Please see an Administrator for details.*

Child's Allergies\* \_\_\_\_\_

Allergic Reaction Symptoms \_\_\_\_\_

Special Dietary Concerns \_\_\_\_\_

*Complete an Allergy Action Plan with a physician's order detailing allergies. Please see an Administrator for details.*

## Parent Authorization

**Outerwear (coats, hats, etc.) sign off**  Yes  No

I give permission for Dr. Day Care / Kids Klub to choose which outerwear items to wear or not wear during outside play (example: coat, jacket, sweater, hat, mittens/gloves), based on the weather

Our outdoor play philosophy is play-based, meaning that children learn as they play! All children will go outdoors every day, weather permitting. Weather permitting means almost every day, unless there is active precipitation, extremely hot or cold conditions, or public announcements that advise people to remain indoors due to weather conditions such as high levels of pollution, extreme cold or heat that might cause health problems. Outdoor times are allocated on the daily schedule. To ensure each child is dressed for outdoor play, if a child brings in outerwear (coat, jacket, sweater, hat, mittens/gloves) to day care/school, they must wear the item(s) outside, unless the parent signs off otherwise.

## Photograph and Video Permission

Yes I give Dr. Day Care staff permission to take photographs and/or videos of my child for public relations and /or marketing purposes. This includes the Parent Engagement app that is used to send daily updates to parents. Photos will remain archived at Dr. Day Care Home Office and can be used for promotional purposes without notification.

No My child may not have photographs or videos used for public relations or marketing purposes. I understand that photographs will not be included in the Parent Engagement app that is used to send daily updates. **Please select "No" if your child is a foster child in DCYF custody.** Photos of my child may still be used in the classroom **only** for educational purposes (ie, Cubby Tags, Portfolios, etc).

**School Department Permission (School Age Only)**  Yes  No  Not Applicable

I give Dr. Day Care staff permission to obtain medical and federal food program forms from the elementary school's designee. I give Dr. Day Care staff permission to communicate with school department teachers/ staff regarding homework and tutoring assistance for my child.

Dr. Day Care programs are designed to enhance and reinforce each stage of your child's development. If concerns or questions should arise regarding your child's participation, all parties will reach a solution. Dr. Day Care enjoys your child and provides a happy, healthy, educational and enriching environment for them and hopes to meet your expectations. If you have any concerns about any of the above listed, please make a note here:

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If applicable:

**DCYF Primary Worker Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Parent Agreement Contract

(page 1 of 2)

Start Date \_\_\_\_\_

Child's Name \_\_\_\_\_

Site \_\_\_\_\_

Please fill in the hours needed for the program on the corresponding day (for example, M-F, 8am-4pm).

Full-time child care shall not exceed 50 hours per week, or 10 hours per day.

Monday	Tuesday	Wednesday	Thursday	Friday

The tuition for services will be: \$ \_\_\_\_\_ per week, based on the above schedule.  DHS copay

**Weekly Method of Payment:**

Automatic recurring payments via secure link

Non-automatic weekly payment in app

Cash or Check

For security and compliance purposes, all credit card, debit card, and bank draft information must be entered exclusively via a secure payment link or via mobile app. The payment link will be sent when enrollment is confirmed. Under no circumstances will any representative of this organization collect, input, or handle any customer credit card or bank account information.

**In consideration, I/we, as parent(s) or guardian, enroll or re-enroll our child at Dr. Day Care Inc. with the understanding of the following:**

- To secure a space for your child, a non-refundable registration fee and first week's tuition is required.
- A one-time Registration fee is charged per child or family upon enrollment. An annual Activity fee will be charged the 3rd week of September. Registration and Activity fees are outlined on the current year's tuition rate sheet.
- I understand that anyone listed on the Method of Payment Agreement may receive financial statements and financial information on the account.
- The tuition and registration payment is due on or before the first day your child begins care. Thereafter tuition is due each Friday at noon before the upcoming week of service. If paying by check, please write your child's name on the memo portion of your check and the week your payment is for. All automatic payments will be processed the Friday prior to services.
- Our billing system automatically charges a \$15.00 fee to any account not paid by Friday at the close of business.
- If hours of care for a child exceed the contracted amount, the parents/guardians will be subject to additional tuition for the overage in hours (i.e. 3 days of care to 4 days of care). Based on available space. (tuition only)
- If weekly hours of care for a child exceeds what DHS approved for the family, the parents/guardians will be subject to a fee for the weekly overage in hours, which will be the difference between what the family is approved for by DHS and what hours were actually attended (i.e. 3/4 time to full time). Based on available space. (DHS subsidy only)
- Accounts in arrears may be subject to termination and parent/guardian is responsible for litigation.
- There will be a \$35.00 charge for all returned ACH payments or checks.
- Late departures after closing are subject to a one dollar per minute late fee. After closing, if Dr. Day Care is unable to contact you or the emergency contacts provided, local authorities will be called after a reasonable amount of time has passed.
- No child will be cared for when sick with an infectious illness, for the well-being of your child, as well as others. Credit cannot be issued for a child who is out sick. For extended absences due to illness, parents may choose to use two week's vacation credit. Please speak with site Administrator or call our billing department (401-723-2277).

# Parent Agreement Contract

(page 2 of 2)

- When terminating a child's enrollment, a one-week notice must be given in writing to the site Administrator. If no notice is given, your account will be billed accordingly.
- Vacation Credit - 2 weeks are allowed per year (Sep. – Aug.) at  $\frac{1}{2}$  of your regular tuition rate and you may have your child attend  $\frac{1}{2}$  time in day increments only. See Administrator for more information.
- To maintain proper staff/student ratio, agreed upon dates and times on this contract can only be altered when another contract is completed.
- Please contact your Administrator as soon as possible if you need to change any of your personal information or schedule (examples: emergency person, address, home/work telephone numbers, times, fees, medical info, etc.).
- Dr. Day Care will be closed for holidays and other closings. The center's hours and holiday schedules are set annually, but may change at any time. The weekly tuition payments will remain the same. Note: part-time enrollees, if your child is scheduled to attend on a holiday or other school/site closure, another day may be substituted only if staff/student ratio allows. Our program policy is to remain open unless the Governor declares a State of Emergency, we receive a state mandate, or unforeseen circumstances that compromise the safety of our children, staff, and families.
- Inclement Weather/ Professional Days/ Election Days- (this section is only applicable for children in our school age program) on days when the Elementary School is closed and Dr. Day Care is open, due to Inclement Weather, Professional Days, or Election Days, an additional fee will be added to your regular rate if your child attends. Charges are as followed: \$20 additional if your weekly tuition is before and after school rate, \$25 additional if your weekly tuition is after school rate, and \$35 additional if your weekly tuition is before school rate. If a child is not scheduled for a given day and requires full day care, they will be charged the daily School Vacation rate.
- I hereby release Dr. Day Care, Inc., its officers, Administrators, and employees from all liability for injury to my child, in excess of the amount payable under the insurance carried by Dr. Day Care, Inc.
- I agree that this Waiver and Release of Liability shall apply to each day my child attends a Dr. Day Care, Inc. and/or any related entity's facility regardless of the date this form is signed below. I agree that I will assume the risk and full responsibility for any and all injuries, losses, or damages, that might occur to my child or any other family members while on the premises or while participating in any off-site program or activity. I agree to waive and release any and all claims, suits or related causes of action against Dr. Day Care, Inc., and/or related entities, their owners, officers, employees, or agents for injury, loss, death, costs or other damages incurred by my child, me, my heirs or assigns, or any third parties for claims, suits or related causes of action asserted against Dr. Day Care Inc., and/or any related entities, arising from my child's conduct and/or my conduct and/or the conduct of my family members or guests while participating in any programs/activities. I further agree to release, indemnify and hold Dr. Day Care Inc., and/or any related entities, harmless from any liability whatsoever for any future claims presented by my child or any persons acting on my child's behalf for any injuries, losses or damages.
- I acknowledge that I received and reviewed the Family Handbook.

Dr. Day Care does not discriminate on the basis of race, color, sex, handicap, religion or national origin. Dr. Day Care reserves the right at their sole discretion to refuse an application or dismiss a child from our program.

Parent/Guardian #1 Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date Signed: \_\_\_\_\_

Parent/Guardian #2 Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date Signed: \_\_\_\_\_

# Developmental History Form - Infants & Toddlers (6 weeks- 35 months old)

Child's Full Name: \_\_\_\_\_

List child's family  
members: \_\_\_\_\_

Names and ages of child's siblings: \_\_\_\_\_

members: \_\_\_\_\_

## Child's Development

Does your child sit up? \_\_\_\_\_ Crawl? \_\_\_\_\_ Walk? \_\_\_\_\_ Talk? \_\_\_\_\_

Any speech difficulties or concerns?  Yes  No

Language spoken at home? \_\_\_\_\_

Special words used to describe needs: \_\_\_\_\_

History of colic? \_\_\_\_\_ When? \_\_\_\_\_

Does your child use a pacifier or suck thumb? \_\_\_\_\_ When? \_\_\_\_\_

What are your child's typical fussy behaviors? \_\_\_\_\_ When do these typically occur? \_\_\_\_\_

What has been the most effective to handle this time of day? \_\_\_\_\_

## Health

Any known complications at birth? \_\_\_\_\_ Serious illnesses and/or hospitalizations? \_\_\_\_\_

Special physical conditions or disabilities? \_\_\_\_\_

Weight at birth? \_\_\_\_\_

Additional concerns? \_\_\_\_\_

## Eating Habits

Types of food child eats:  Bottle  Jar Baby Food  Table Foods Does your child use a bottle or sippy cup? \_\_\_\_\_

Describe child's self-feeding skills: \_\_\_\_\_

Food Restrictions or Concerns? \_\_\_\_\_

Time child typically wakes up in the morning: \_\_\_\_\_ Does child usually sleep through the night? \_\_\_\_\_ Child's usual bedtime: \_\_\_\_\_

Who else shares the bedroom? \_\_\_\_\_ Daily nap schedule(s): \_\_\_\_\_

Additional Sleeping Notes/Suggestions: \_\_\_\_\_

**For crib sleepers:** Dr. Day Care follows the guidelines set forth by the American Academy of Pediatrics and places children on their backs during rest time. If you would like your child to be placed in a different position, please obtain a note from your child's pediatrician describing how to place your child in his/her crib.

We also do not place any items in your child's crib (except for a pacifier if specified by parent).

## Diapers and Toileting

Are Disposable or Cloth diapers used at home? \_\_\_\_\_ Does child frequently get diaper rash?  Yes  No

Do you use  Oil  Powder  Lotion  Other: \_\_\_\_\_

Has potty training been attempted?  Yes  No Is there a problem with constipation or diarrhea?  Yes  No

Is child potty trained?  Yes  No Child's word for urination: \_\_\_\_\_ Bowel movements: \_\_\_\_\_

How does your child indicate bathroom needs (special words used)? \_\_\_\_\_

Is your child ever reluctant to use the bathroom? \_\_\_\_\_

Does your child have accidents? \_\_\_\_\_ How are they handled (words used, etc)? \_\_\_\_\_

## Play and Social Relationships with Others

Child's typical personality: \_\_\_\_\_

Favorite Stories: \_\_\_\_\_

Favorite Toys: \_\_\_\_\_

How do you typically comfort your child? \_\_\_\_\_

What method of behavior management/discipline does your family use at home? \_\_\_\_\_

Typical reaction to strangers: \_\_\_\_\_ Does child play or have access to a yard?  Yes  No

Has child had other group experiences?  Yes  No Typically prefers to:  Play alone  Play with children  Play with adults

If "yes," please check all that apply:  Sunday School  Nursery School  Play Groups  Child Care

## For previous child care experiences, please provide additional information:

Program Name: \_\_\_\_\_ Program Name: \_\_\_\_\_

Dates attended: \_\_\_\_\_ Dates attended: \_\_\_\_\_

Reason(s) for leaving: \_\_\_\_\_

Reason(s) for leaving: \_\_\_\_\_

Does your child have any special needs or a diagnosis that we should be aware of? \_\_\_\_\_

**Any additional information that may assist us in caring for your child** (i.e. emotional, social, physical or behavioral information which would be important for us to know that includes specifics about his/her personality and temperament):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Developmental History Form - Preschool (3 - 5 years old)

Child's Full Name: \_\_\_\_\_  
Names and ages of child's siblings: \_\_\_\_\_

List child's family  
members: \_\_\_\_\_

## Eating Habits

Likes: \_\_\_\_\_ Dislikes: \_\_\_\_\_  
Time(s) of meals: \_\_\_\_\_ Typical Meal Routines: \_\_\_\_\_

## Sleeping Routines

Time child typically wakes up: \_\_\_\_\_ Child's usual bedtime: \_\_\_\_\_  
Does child usually sleep through the night? \_\_\_\_\_ Daily nap schedule(s): \_\_\_\_\_  
Who else shares the bedroom? \_\_\_\_\_  
Does your child require any special rest items? Please list them here: \_\_\_\_\_  
Additional Sleeping Notes/Suggestions: \_\_\_\_\_

## Dressing and Toileting

Can child dress self?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Does child wear diapers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Areas that need help:	_____	Child's term for urination:	_____
Comb his or her own hair?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Child's term for bowel movement:	_____
Manage zippers?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Has potty training been attempted?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Manage buttons?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is child potty trained?	<input type="checkbox"/> Yes (at what age: _____) <input type="checkbox"/> No
Does your child have accidents?	_____	How are they handled (words used, etc)?	_____

## Discipline

How is your child disciplined at home? \_\_\_\_\_  
Any special discipline concerns? \_\_\_\_\_  
Does your child help around the house?  Yes  No How? \_\_\_\_\_

## Play and Social Relationships with Others

Main play interests: \_\_\_\_\_  
Favorite Stories: \_\_\_\_\_ Favorite Toys: \_\_\_\_\_  
Does child play or have access to a yard?  Yes  No Types of equipment child is familiar with: \_\_\_\_\_  
Typically prefers to:  Play alone  Play with other children  Play with adults  
Has child had other group experiences?  Yes  No  
If "yes," please check all that apply:  Sunday School  Nursery School  Play Groups  Child Care

Typical reaction to strangers: \_\_\_\_\_  
How do you typically comfort your child? \_\_\_\_\_  
What method of behavior management/discipline does your family use at home? \_\_\_\_\_

## For previous child care experiences, please provide additional information:

Program Name: \_\_\_\_\_ Program Name: \_\_\_\_\_  
Dates attended: \_\_\_\_\_ Dates attended: \_\_\_\_\_  
Reason(s) for leaving: \_\_\_\_\_ Reason(s) for leaving: \_\_\_\_\_

Does your child have any special needs or a diagnosis that we should be aware of? \_\_\_\_\_

**Any additional information that may assist us in caring for your child** (i.e. emotional, social, physical or behavioral information which would be important for us to know that includes specifics about his/her personality and temperament):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



# Physical and Immunization Records

Please contact your child's physician to get a copy of all medical records prior to enrollment and after **every** doctor visit.

School Name & Address:



Health Care Provider Name and Address:

Phone:

## STATE OF RHODE ISLAND SCHOOL PHYSICAL FORM

This form may substitute for any district-issued form. All districts must accept this form. General health examinations shall be documented in a standardized format with one copy available from the Rhode Island Department of Health or in any such format that captures the same fields of information (R16-21SCHO Section 8.4)

Student Name: Last	First	Middle	Date of Birth	Sex
Address: Street		Apt #	City	State Zip Code Home Phone

PLEASE COMPLETE ALL INFORMATION BELOW (May attach immunization transcript).

IMMUNIZATIONS Please enter dates in MM/DD/YYYY format					
Hepatitis B					
Diphtheria-Tetanus-Pertussis DTP/DTaP	Check D if DT	Check D if DT	Check D if DT	Check D if DT	Check D if DT
Pneumococcal Conjugate PCV					
Polio					
Haemophilus Influenzae Type B Hib					
Measles-Mumps-Rubella MMR					
Varicella			D Student has history of varicella disease		
Tetanus-Diphtheria-Pertussis TdaP/Td	Check D if Td	Check D if Td	Check D if Td		
Rotavirus					
Hepatitis A					
Meningococcal					
HPV					

Immunization Exemption:  Medical  Religious

D Hep B  D DTaP  D PCV  D Polio  D Hib  D MMR  D Varicella  D Td/Tdap  D Rotavirus  D Hep A  D Mening  D HPV

### PHYSICAL EXAMINATION

Date of PE / / Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_

Please note any health problem, chronic health condition or disability that may affect behavior or health at school:

ASTHMA: No  Yes  DIABETES: No  Yes  OTHER: \_\_\_\_\_

Significant Systems Findings: \_\_\_\_\_

ALLERGIES: No  Yes  (Please explain) \_\_\_\_\_ EPINEPHRINE AUTO-INJECTOR REQUIRED: No  Yes

Treatment Plan: \_\_\_\_\_

MEDICATION (REQUIRED AT SCHOOL): No  Yes  (Please list) \_\_\_\_\_

Other medication(s) that may affect behavior or health at school: \_\_\_\_\_

RESTRICTIONS: Can participate in physical education: Fully  With limitation

Can participate in sports: Fully  With limitation

LEAD SCREENING (Required for children < 6 years of age only) Student is in compliance with lead screening requirements: Yes <input type="checkbox"/> No <input type="checkbox"/>	SCOLIOSIS SCREENING Yes <input type="checkbox"/> No <input type="checkbox"/>	VISION SCREENING (Children entering Kindergarten) [J Passed screening [J Screened and referred for comprehensive exam [J Referred for comprehensive exam, but not screened
--	---	---

TUBERCULOSIS (If required by school district) Date of TB test:	Screening Date: _____	Comprehensive Exam Date: _____
---	-----------------------	--------------------------------

HEALTH CARE PROVIDER SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_

Revised 7-10

# DHS Child Care Subsidy

This page is for families which receive child care subsidy (CCACP) from the Rhode Island Department of Human Services (DHS). All forms must be filled out completely. If you do not receive DHS financial assistance you do not need to fill out this information.

Child's Full Name: \_\_\_\_\_ Site of Enrollment: \_\_\_\_\_

**DHS Certificate Number:** \_\_\_\_\_

Forms to complete:

- DHS Family Consent Form
- DHS Absenteeism Form Letters (in case of extended absences)
- Parent Agreement Contract Addendum
- Parent Provider Agreement Form (**Administrator prints from DHS website**)

## DHS Family Consent Form

Today's Date: \_\_\_\_\_

To Whom It May Concern:

I (*parent name who is applying - please print*) \_\_\_\_\_ authorize the staff and members of Dr. Day Care/Kids Klub, Inc. to advocate on my behalf with officials at the Rhode Island Department of Human Services. Further, I authorize the Department of Human Services to release and discuss any and all relevant information about my case with these representatives of the day care. Please contact me with any questions or concerns.

My child(ren)'s names:

\_\_\_\_\_  
(Please list each child's first and last names)

Signed, \_\_\_\_\_

Address: \_\_\_\_\_ State & Zip Code: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

## Parent Agreement Contract Addendum

If weekly hours of care for a child exceeds what DHS approved for the family, the parents/guardians will be subject to a fee for the weekly overage in hours, which will be the difference between what the family is approved for by DHS and what hours were actually attended (i.e. 3/4 time to full time).

(i.e. If a family is allowed  $\frac{3}{4}$  time by DHS (CCAP) for a preschool child and they exceed 30 hours of care for their child a fee will be added for the additional child care services, which is the difference between the  $\frac{3}{4}$  reimbursement rate and the full time reimbursement rate.)

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# DHS Absenteeism Form Letter



Rhode Island Department of Human Services  
 Office of Child Care  
 25 Howard Avenue, LP Bldg. 1<sup>st</sup> Floor  
 Cranston, R.I. 02920  
 (401) 462-6877

## Child Care Assistance Program (CCAP) Authorization for CCAP Payment During a Child's Absence

Families receiving CCAP benefits are eligible for up to two consecutive weeks of allowable absences at a time without impacting provider payment. Allowable absences include absences with notice that are accompanied by a parent notice (signed by the parent). Parental notice is required for absences that are five consecutive days in a week.

By completing the form below, you are authorizing DHS to provide payment to your child care provider during your child's absence from the program and you agree not to enroll your child with another child care provider during this time. **If you plan to take your child to another CCAP provider during this time, please do NOT submit this form, as DHS will not issue payment to more than one provider for the same hours of care.**

Provider ID:	
Provider Name:	
Parent Name:	
Certificate Number:	
Child(ren)'s Name(s):	
Dates of Child(ren)'s Absence:	
Reason for Absence:	

*I certify that the information reported on this form is true and accurate.*

\_\_\_\_\_  
 Signature of Parent

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature of Provider

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Provider Printed Name

\_\_\_\_\_  
 Position/Title

Providers: please ensure this form is complete, including parent signature, and upload with your attendance submission. *No CCAP payment will be made for absences longer than two consecutive weeks or for absences five days or longer that are not accompanied by an authorization for payment absentee form signed by the parent.*

# Infant Meals for infants not yet on table food (6 weeks – 11 months old)

Select Dr. Day Care locations participate in the Child Care and Adult Food Program (CACFP). Ask your Administrator if your child's center is a CACFP participating center. **This form is to be completed for all infants not yet on table food**, please see an Administrator or view website for a sample menu if your child is on table foods.

Child's Full Name: \_\_\_\_\_

Dr. Day Care location: \_\_\_\_\_

○ **CACFP participating center:**

I will be providing my child's own formula or breastmilk, baby cereal, and/or jarred baby food.

Please provide my child with formula (Walmart Parent's Choice Advantage iron-fortified formula or BJ's Wellsley Farms Advantage Premium Infant Formula Milk Based Powder with Iron)

I understand that if I choose to have Dr. Day Care provide formula, I am responsible for supplying at least 4 clean, sterilized bottles each day (labeled with my child's name) along with all bottle supplies (nipples, covers, liners, etc.). At the end of each day, bottles and supplies will be returned to you.

Has your child been exposed to other formulas or breast milk prior to utilizing the Dr. Day Care iron-fortified formula?  Yes  No  
If yes, please list previous formulas here:

Please provide my child with baby cereal and jarred baby food

○ **Not a CACFP participating center:**

I understand I will be providing my child's own formula or breastmilk, baby cereal, and/or jarred baby food.

**Additional information that may assist us in the feeding of your child:**



Parent/Guardian Printed Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date Signed: \_\_\_\_\_

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U.S. Department of Agriculture

## Women, Infants, and Children Program (WIC)

- Pregnant or postpartum women, infants, and children up to age 5 are eligible for WIC.
- You must live in RI, and be individually determined to be at "nutritional risk" by a health professional, AND
- You must meet income guidelines.
  - A person or certain family members automatically meets the family income eligibility requirements by participating in Supplemental Nutrition Assistance Program (SNAP), Medicaid, or RIWorks OR
  - Your gross income (before taxes are withheld) must fall at or below 185 of the U.S. Poverty Income Guidelines:

**WIC Income Eligibility Guidelines  
(Effective from July 1, 2025 to June 30, 2026)**

Household Size	Annual	Monthly	Twice-Monthly	Bi-Weekly	Weekly
1	28,953	2,413	1,207	1,114	557
2	39,128	3,261	1,631	1,505	753
3	49,303	4,109	2,055	1,897	949
4	59,478	4,957	2,479	2,288	1,144
5	69,653	5,805	2,903	2,679	1,340
6	79,828	6,653	3,327	3,071	1,536
7	90,003	7,501	3,751	3,462	1,731
8	100,178	8,349	4,175	3,853	1,927
Each add'l member, add	+\$10,175	+\$848	+\$424	+\$392	+\$196

This institution is an equal opportunity provider.



**What are the benefits?**

WIC participants receive:

- Supplemental Nutritious foods
- Nutrition education and counseling at WIC clinics
- Screening and referrals to other health, welfare and social services

In RI, WIC participants receive WIC checks to purchase specific foods each month which are designed to supplement their diets. WIC foods include iron-fortified infant formula and infant cereal, iron-fortified adult cereal, vitamin C-rich fruit and/or vegetables juice, eggs, milk, cheese, peanut butter, dried beans or peas, tuna fish and carrots. Special infant formulas and certain medical foods may be provided when prescribed by a physician or health professional for specified medical condition.

Below is the RI WIC website  
<http://www.health.ri.gov/programs/wic/>

Or

Call for information on sites near you.

Telephone: (401) 222-4623

Toll free (in-state): 1-800-942-7434

TDD: 1-800-745-5555

# Meals Served Enrollment Form (CACFP)

To verify the enrollment of your child in this child care center complete the following information, sign and date this form and return it to the day care center. The Administrator will review this completed form before submitting to the Dr. Day Care Finance Department.

Dr. Day Care participates in the U. S. Department of Agriculture Child and Adult Care Food Program (CACFP). This program helps us provide nutritious meals and snacks to children enrolled at our center. The requirements and portion sizes for those meals and snacks are included as an attachment to this enrollment form. Under the regulations of the CACFP, you are not charged separate fees for meals nor may you be asked to provide food for your children for those meals or snacks claimed under the program. Regular day care fees cover the cost of care and food costs not reimbursed by the CACFP.

Check here ONLY if you are choosing **not** to enroll your child in CACFP, then sign and date the bottom of the form:

*I do not want my child to participate in the Child and Adult Care Food Program (CACFP)*

**To verify the enrollment of your child in this child care center complete the following information, sign and date this form and return it to the day care center.**

**Child's Full Name:** \_\_\_\_\_ **Dr. Day Care Location:** \_\_\_\_\_

**First Day of Attendance:** \_\_\_\_\_ **Month, Date & Year of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_

My child will normally be in child care during the following days and times and receive the meals as indicated below:

<b>① Child Information</b>		<b>② Days of Attendance</b>		<b>③ Times Child Normally Attends During Week</b>		<i>(If child leaves for School)</i>		<b>④ Meals Served</b>
Date of Birth / /	Age* / /	First Day of Attendance / /	<input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday	Arrival Time	Departure Time	Leaves Center	Returns to Center	<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Snack

\*For infants ages 6 weeks – 11 months old, please ALSO complete the Infant Meals portion of this form below

**Parent/Guardian Printed Name:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_

**Address (please print):** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date Signed:** \_\_\_\_\_

**Administrator's Signature (Sponsor Representative):** \_\_\_\_\_ **Date Signed:** \_\_\_\_\_

## Building for the Future

This day care facility participates in the Child and Adult Care Food Program (CACFP), a Federal program that provides healthy meals and snacks to children receiving day care. Each day more than 2.6 million children participate in CACFP at day care homes and centers across the country. Providers are reimbursed for serving nutritious meals that meet USDA requirements. The program plays a vital role in improving the quality of day care and making it more affordable for low-income families.

**Meals** CACFP homes and centers follow meal requirements established by USDA.

Breakfast	Lunch or Supper	Snacks (Two of the five groups: )
Milk Fruit or Vegetable Grains	Milk Meat or meat alternate Grains Fruit Vegetable	Milk Meat or meat alternate Grains Fruit Vegetable

**Participating Facilities** Many different homes and centers operate CACFP and share the common goal of bringing nutritious meals and snacks to participants. Participating facilities include:

- **Child Care Centers:** Licensed or approved public or private nonprofit child care centers, Head Start programs, and some for-profit centers.
- **Family Day Care Homes:** Licensed or approved private homes.
- **Afterschool Care Programs:** Centers in low-income areas provide free snacks to school-age children and youth.
- **Homeless Shelters:** Emergency shelters provide food services to homeless children.

**Eligibility** State agencies reimburse facilities that offer non-residential day care to the following children:

- Children age 12 and under
- Migrant children age 15 and younger, and
- Youths through age 18 in afterschool care programs in needy areas

**Contact Information** If you have questions about CACFP, please contact one of the following:

**Sponsoring Organization:**  
Dr. Day Care  
1201 Douglas Pike, Ste 4, Smithfield, RI 02917 (401) 475-7707

**Child Nutrition Programs**  
RI Department of Education  
255 Westminster Street, Providence, RI 02903 (401) 222-4600

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# CACFP Meal Benefit Income Eligibility Form Instructions

The Child and Adult Care Food Program (CACFP) makes good food a regular part of your child's day care! Please fill out the CACFP Meal Benefit Income Eligibility form.

**Step 1:** List all the children from your household in the day care. Use one line for each child's name. Write one letter in each box. Stop if you run out of space. If there are more children, add their names on a second piece of paper.

Do you have any foster children? If you answer Yes, mark the Foster Child box next to the child's name. If you are only applying for foster children, finish Step 1 and go to Step 4. If you are applying for both foster and non-foster children, go to Step 2.

Are any children migrant, runaway, homeless, or enrolled in Head Start? If Yes, mark the correct boxes next to the child's name and go to Step 4.

**Step 2:** You qualify for free meals if you live in a household that receives Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR).

Do any household members, including you, currently receive SNAP, TANF, or FDPIR? If Yes, write the case number in the box and go to Step 4. You only need to provide one case number. If No, go to Step 3.

**Step 3:** Report current income for all household members. Skip this step if you answered Yes in Step 2.

How do you report child income? Turn the form over and use the Source of Income for Children chart to see if your household has income to report. Write the amount in the boxes in part A of the form. Mark how often the amount is earned. Write 0 in the box if there is no income to report.

How do you report income of adult household members? Turn the form over and use the Source of Income for Adults chart to see if your household has income to report. In part B, list all the adults in your household, including you, even if each of you doesn't receive income. Include all adults, such as grandparents, other relatives, and friends who live with you and share household income and expenses. Write the amount of income each of you receives, in the boxes next to your names. Mark how often the amount is received. Write 0 in the box if there is no income to report.

Make sure you report the current amount of money you get before taxes. Don't include SNAP, FDPIR, WIC, student financial aid, or money you receive for a foster child as income.

Count the number of all children and adults in your household. Include all infants, children, students, and adults. Write the total number in the box under the list of adult household members.

Do you or another adult household member have a Social Security number? Write the last four digits in the boxes. If there is no Social Security number, mark the Check if no SSN box.

## Points to Remember:

If:

Your income isn't always the same

Then:

List the amount of money that you normally get. For example, don't include overtime pay, if you don't normally get it. If your income is normally higher or lower, you can report annual income instead.

Your household includes members who aren't citizens

You or your children don't have to be U.S. citizens to qualify for meal benefits.

You are in the military

Don't include your Family Subsistence Supplemental Allowance (FSSA), combat pay, or the money you receive for privatized housing. If deployed, count the amount of pay that is made available to your household as income.

**Step 4:** An adult household member must sign this form. The signer promises that all information is true and complete. Print the name, address, and telephone or email of the adult signer. Sign and write today's date in the marked boxes.

## Optional

We ask about your children's ethnicity and race to make sure we do our best to serve our community. Providing this information is not required. You won't be denied benefits based on your race, color, national origin, sex, age, or disability.

## Letter to Parents (Non-Pricing Centers)

Dear Parent or Guardian:

Dr. Day Care offers healthy meals and snacks to children as part of the Child and Adult Care Food Program (CACFP). We receive support from CACFP to serve those meals. CACFP gives more support if your household income is less than or equal to the limits on this chart:

Federal Income Standards for Reduced-Price Meals for July 1, 2025 - June 30, 2026		
Household Size	Yearly Income	Monthly Income
1	\$28,953	\$2,413
2	39,128	3,261
3	49,303	4,109
4	59,478	4,957
5	69,653	5,805

Please fill out a CACFP Meal Benefit Income Eligibility form. It will help us find out how much support Dr. Day Care receives. Please be sure to read the instructions carefully. Fill in all the information we request. We can only accept complete forms. Please send the completed form to your center Administrator.

Thank you for taking the time to fill out the form. We hope your child enjoys CACFP meals!

In the operation of child nutrition programs, no person will be discriminated against because of race, color, national origin, sex, age, or disability.

If you have questions or need help, please contact Dr. Mary Ann Shallcross Smith at 401-475-7707 or [info@drdaycare.com](mailto:info@drdaycare.com)

Dr. Mary Ann Shallcross Smith

Sponsor Representative Signature

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Visit <https://vote.gov> to find more information about local, state, and federal elections and how you can participate.  
Check Voter Registration Deadlines and Laws in Your State at [Vote.gov](https://vote.gov)



Source of Income for Children	
Sources of Child Income	Examples
Earnings from work	<ul style="list-style-type: none"> <li>A child has a regular full or part-time job where they earn a salary or wages</li> </ul>
Social Security <ul style="list-style-type: none"> <li>Disability Payments</li> <li>Survivors Benefits</li> </ul>	<ul style="list-style-type: none"> <li>A child is blind or disabled and receives Social Security benefits</li> <li>A parent is disabled, retired, or deceased, and their child receives Social Security benefits</li> </ul>
Income from person outside of household	<ul style="list-style-type: none"> <li>A friend or extended family member regularly gives a child spending money</li> </ul>
Income from any other source	<ul style="list-style-type: none"> <li>A child receives regular income from a private pension fund, annuity, or trust</li> </ul>

Source of Income for Adults		
Earnings from Work	Public Assistance/Alimony/Child Support	Pensions/Retirement/All other sources of income
<ul style="list-style-type: none"> <li>Salary, wages, cash bonuses</li> <li>Net income from self-employment (farm or business)</li> </ul> <b>If you are in the U.S. Military:</b> <ul style="list-style-type: none"> <li>Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances)</li> <li>Allowances for off-base housing, food, and clothing</li> </ul>	<ul style="list-style-type: none"> <li>Unemployment benefits</li> <li>Workers compensation</li> <li>Supplemental Security Income (SSI)</li> <li>Cash assistance from State or local government</li> <li>Alimony payments</li> <li>Child support payments</li> <li>Veterans benefits</li> <li>Strike benefits</li> </ul>	<ul style="list-style-type: none"> <li>Social Security (including railroad retirement and black lung benefits)</li> <li>Private Pensions or disability benefits</li> <li>Income from trusts or estates</li> <li>Annuities</li> <li>Investment income</li> <li>Earned interest</li> <li>Rental income</li> <li>Regular cash payments from outside household</li> </ul>

### OPTIONAL 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  Native Hawaiian or Other 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 Supplemental Nutrition Assistance Program (SNAP), 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, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

**To file a program complaint of discrimination**, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter 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

**FAX:** (202) 690-7442; or  
**EMAIL:** [program.intake@usda.gov](mailto:program.intake@usda.gov).

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

### DO NOT FILL OUT For official use only

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

Total Income

How often?

Weekly	Bi-Weekly	Monthly	2x Month
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Household size

Eligibility

Categorical Eligibility <input type="checkbox"/>	Free <input type="radio"/>	Reduced <input type="radio"/>	Denied <input type="radio"/>
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Determining Official's Signature

Date

Confirming Official's Signature

Date

Follow-up Official's Signature

Date

# Dr. Day Care Information

Dr. Day Care is founded by Mary Ann Shallcross Smith, Ed.D., known as "Dr. Day Care." Mary Ann began her career as an early childhood and school age professional in 1972, when she started her licensed home based day care in Lincoln, RI.

The Dr. Day Care family is comprised of the following:

- **Child Care Consultants & Facilities Management** - oversees Dr. Day Care, Kids Klub, and Therapeutic Child Care Services and ensures compliance with all regulatory agencies.
- **Dr. Day Care Learning Center** - our learning centers utilize a unique curriculum that is based on the latest research on how children learn and develop early literacy, math, comprehension, physical, and social skills. Our extraordinary administrators and educators create nurturing and secure environments where children are eager to learn in a way that's natural and fun for them. We are the Home of the Educational Guarantee!
- **Kids Klub** - a non-profit child care organization that was co-founded by Dr. Mary Ann Shallcross Smith and Dr. Karen Annotti in 1987. Originally a single location in Lincoln, RI, Kids Klub has evolved into multiple locations throughout Rhode Island. Kids Klub provides a safe, supervised environment with activities that enhance the student's environment with activities that enhance the student's physical, emotional, social, and cognitive development.
- **Therapeutic Child Care Services (TCCS)** - a service developed by the Rhode Island Department of Human Services (DHS) that provides specialized services for children and youth with special needs. This gives children and youth the opportunity to learn, play, and socialize with their friends. TCCS supports children with special needs in a mainstream setting. Through an inclusive integrated environment, TCCS offers services by trained professionals that meet the needs of all children.

**Thank you for choosing to be a part of  
Dr. Day Care!**

**Connect with us:**

web - [www.drdaycare.com](http://www.drdaycare.com)

facebook - [@drdaycarer1](https://www.facebook.com/drdaycarer1)

instagram - [@drdaycarelearningcenter](https://www.instagram.com/drdaycarelearningcenter)

**Our Mission Statement:** To provide family, youth and child services in a safe, structured, and nurturing environment through a team of dedicated professionals.