

Child's Personal Data Sheet

1. Name _____ DOB _____

Father's Name _____ Mother's Name _____

Home Address _____

City _____ State _____ ZIP _____ Phone _____

Father's Employer _____ Work Phone _____ Work Hours _____

Mother's Employer _____ Work Phone _____ Work Hours _____

Date enrolled in center _____ Date withdrawn from Center _____

Name of Center _____ Clock hours in Care _____



2. Emergency Contact Information

Name of person to call if parents cannot be reached _____

Relationship _____ Telephone _____

Address _____ City _____ State _____ ZIP _____

Is this person authorized to take the child from the center? _____

List all other adults who are authorized to take the child from the center:

Name	Relationship	Name	Relationship	Name	Relationship
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____



3. Medical Information

Child's Physician or emergency treatment facility _____

Address _____ City _____ State _____ Phone _____

I, _____
Father
Mother (CROSS OUT WORDS THAT DO NOT APPLY) of
Guardian
_____ do hereby give my consent to the Director of the Child Care Facility, or his
(Child's Name)

duly representative, for said child to receive medical or surgical aid as may be deemed necessary and expedient by a duly licensed or recognized physician or surgeon in case of an emergency when the parents cannot be reached. Consent is also given for the Director or his duly appointed representative to transport said child for emergency medical treatment, if the parents cannot be reached.

Signed _____ Date _____ Witness _____ Date _____

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I hereby give ____ / do not give ____ the Director of the Child Care Facility or his appointed representative

permission to give _____ acetaminophen. I understand I will be notified
(Child's Name)
that the medication has been administered.

Signature _____ Date _____



4. Immunizations: Please Provide a copy of your Child's Immunization Record.

Verified by Health Department Record _____ Physician's Record _____ Other _____



5. Disease History: List the dates of each:

Measles _____ Mumps _____ German Measles _____ Chicken Pox _____ Whooping Cough _____

Contracted Tuberculosis: Yes _____/No _____ Frequent Ear Infections Yes _____/No _____

Frequent Throat infection Yes _____/No _____ Defective Heart Yes _____/No _____

Other Conditions or Comments _____



6. Child's developmental needs:

Physical or emotional problems the child might have: _____

Child's special food needs: Formula _____ Diabetic diet _____ Allergies _____

Special problems: Medications _____

Allergies _____ Temper Tantrums _____ Diabetes _____ Frequent colds _____

Biting _____

Sun Sensitivity _____ Seizures _____ Fainting Spells _____ Bed wetting _____ Other _____

Requires help in: Dressing _____ Undressing _____ Toileting _____ Eating _____ Washing hands _____

Is Child toilet trained? Yes _____/No _____ Words used in toileting _____

Favorite: Games _____ Toys _____ Foods _____

Siblings? Yes _____/No _____ Name(s) of siblings: _____

Type of child care used before _____

Other useful information _____



7. I, the parent/guardian of this child, understand that I may ask for a conference with the caregiver(s) as needed.

Signature _____

Date _____



Additional comments: _____

ACCIDENT REPORT

To be filled out as soon as possible on the day of the incident by the person witnessing the occurrence.
Obtain signature of parent/guardian.

Child's name _____ Parent/Guardian's Name _____

Person in Charge _____ Date of Accident _____ Time of Accident _____

Name of Witnesses: _____

Describe Injury: _____

Describe Accident (What happened) _____

Place or Accident (Area, and include any equipment or products involved) _____

Who was notified (Parent/Relative), When, Date, Hour, and by whom: _____

Describe Actions taken by Staff,(i.e. First Aid) _____

Services provided by Medical Personnel? If so include who, what, when, and where. _____

Could this incident have been avoided? _____ If yes, then how? _____

Staff Comments _____

(Staff Completing Report) Signature

Parent/Guardian Signature & Date

Application for Employment

NOTE Please answer each question fully and accurately. No action can be taken on this application until all questions have been answered. **PLEASE PRINT** except for your signature on the last page.

Job applied for _____ Today's Date _____ Name _____
_____ Phone # _____ Address _____

Are you 18 years of age or older? _____ Social Security # _____

Were you ever employed here? Yes / / No / / If yes, when? _____

Have you ever applied here? Yes / / No / / If yes, when? _____

Number of days missed work in last six months? _____

Has a court ever denied you parental custodial or visitation rights as a result of child maltreatment?

Yes / / No / / If yes, explain _____

_____ Have
you ever been convicted of any of the following : Yes / / No / /

- 1) Capital murder; 2) 1st or 2nd degree murder; 3) Manslaughter; 4) 1st or 2nd degree battery; 5) Aggravated assault; 6) 1st degree terroristic threatening; 7) Kidnapping; 8) 1st degree false imprisonment; 9) Permanent detention or restraint; 10) 1st/2nd degree rape or carnal abuse;
- 11) 1st/2nd degree sexual abuse; 12) 1st/2nd degree violation of a minor; 13) Incest; 14) 1st degree endangering of a minor; 15) Permitting child abuse; 16) Engaging children in sexually explicit conduct for the use in visual or print; medium, transportation of minors for prohibited sexual conduct, use of a child or consent to use of a child in sexual performance, by producing, directing, or promoting sexual performance by a child; 17) Criminal attempt, criminal solicitation or criminal conspiracy to commit any of the above offenses; 18) Distribution to minors, { of any controlled substance}; 19) Manufacture, delivery, or possession with intent to deliver or manufacture of any controlled substance; and, 20) Carnal abuse in th third degree;
- 21) Sexual solicitation of a child; 22) Pandering or possessing visual or print medium depicting sexually explicit conduct involving a child; 23) Negligent homicide; 24) Assault in the third degree; 25) Coercion; 26) Sexual misconduct; 27) Public sexual indecency; 28) Indecent exposure; 29) Endangering the welfare of a minor in the second degree; 30) Any felony or misdemeanor involving violence or sexual misconduct.

EDUCATION (Give name, address, location, highest grade completed, date of leaving)

High School or GED _____ College
or University _____ College major _____
_____ Degree _____ Advanced degree or
course work _____ Additional Education,

Vocational, Technical Training information _____

HEALTH Do you have any physical limitations which would give you problems in performing this job?

Yes / / No / / If yes, explain _____

Would you take a physical examination if required? Yes / / No / /

Do you have documentation of an annual TB skin test? Yes / / No / /

REFERENCES Names, complete addresses, phone numbers of three people (no relatives or former employers) we may contact about you.

1. Name _____
Address _____ Phone (____) _____
2. Name _____
Address _____ Phone (____) _____
3. Name _____
Address _____ Phone (____) _____

WORK HISTORY Please attach a resume or list below all work history for the past six years. If self-employed, supply business references. **PLEASE GIVE MONTH AND YEAR.**

Employer's Name Address and Phone #	From / To	Duties	Last Supervisor	Reason for Leaving

(Continue on a sheet of blank paper if you do not have enough room to list your employers for the past six years)

Are you now or do you expect to be engaged in other business or employment? If yes, explain _____

-

Explain any additional information (relative to name change, use of assumed name or nickname) necessary to enable us to check your work record. _____

-

NARRATIVE

Why do you want to work in our program? _____
What do you feel best qualifies you for this job? _____

AFFIDAVIT I certify that everything in this application is true and correct to the best of my knowledge. I understand that misleading or incorrect statements or consequential omissions may render the application void, or if employed, would be cause for termination. I authorize the individuals or institutions named above to give information regarding my employment, character, and qualification, hereby releasing them from all liability for issuing such information.

Signature _____ Date _____

Date Employed _____ Date of Separation _____

EMPLOYMENT REFERENCE CHECK

Re: _____

—

Contact: _____
Name Title Company

Phone _____

This is _____ With _____

— (your name)

(name of your center)

(Applicant) has applied with us for a job as _____ and has listed you as a former employer. I have his/her authorization for a reference check and I'm verifying some of the information given to us.

1. When did she/he work for you? From _____ To _____.

2. What was the nature of his/her job?

3. How many people, if any, did she/he supervise? For how long?

4. How would you describe his/her performance?

5. How was his/her work attendance?

6. How well did he/she work (get along) with employees and others?

7. What would you say were his/her strong points and weak points?

8. Was she/he dependable?

9. Could you comment on his/her ability to take responsibility?

Signature _____ Date _____

FIELD TRIP PERMISSION

Name of Facility

Field Trip Date

Field Trip Name and Location

Departure Time

Est. Time of Return

Mode of Transportation

Child's Name

EMERGENCY CONTACT INFORMATION

Phone number(s) where parent(s) may be reached: _____
Name of person(s) to call if parent(s) cannot be reached: _____

Telephone: _____ Relationship to child: _____
Address: _____

CONSENT FOR EMERGENCY MEDICAL CARE

I/We _____ Relation: _____ of _____
Child's name

do hereby request and give consent to the Director/Caregiver of the Child Care Facility, or his duly appointed representative, for said child to receive such medical or surgical aid as may be deemed necessary expedient by a duly licensed or recognized physician or surgeon in case of an emergency when the parent(s) cannot be reached. Consent is also given for the Director/Caregiver or his duly appointed representative to transport said child for emergency medical treatment, if parent(s) cannot be reached. I additionally give consent for my child to attend the above named field trip.

Parent/Guardian Signature & Date

Witness Signature & Date

INCIDENT REPORT

To be filled out as soon as possible on the day of the incident by the person witnessing the occurrence.

Child's name _____ Parent/Guardian's Name _____

Person in Charge _____ Date of Incident _____ Time of Incident _____

Describe Incident (What happened) _____

Place or Incident (Area) _____

Name of Witnesses: _____

Who was notified (Parent/Relative), When, Date, Hour: _____

Describe Actions taken by Staff: _____

Could this incident have been avoided? _____ If yes, then how? _____

Staff Comments _____

Signature & Date (Staff Completing Report) Signature Parent/Guardian

INJURY LOG

This form is to be used to log injuries that occur in the facility in order to determine if there are areas in the center where more injuries occur than other places in the center.

Date_____	Time of injury_____	Staff reporting _____	Child's Name_____
Child Age_____	What happened to cause injury?_____		
Where did it happen?_____	Suggested prevention steps_____		
_____	Have steps been taken?/Date_____		
Date_____	Time of injury_____	Staff reporting _____	Child's Name_____
Child Age_____	What happened to cause injury?_____		
Where did it happen?_____	Suggested prevention steps_____		
_____	Have steps been taken?/Date_____		
Date_____	Time of injury_____	Staff reporting _____	Child's Name_____
Child Age_____	What happened to cause injury?_____		
Where did it happen?_____	Suggested prevention steps_____		
_____	Have steps been taken?/Date_____		
Date_____	Time of injury_____	Staff reporting _____	Child's Name_____
Child Age_____	What happened to cause injury?_____		
Where did it happen?_____	Suggested prevention steps_____		
_____	Have steps been taken?/Date_____		
Date_____	Time of injury_____	Staff reporting _____	Child's Name_____
Child Age_____	What happened to cause injury?_____		
Where did it happen?_____	Suggested prevention steps_____		
_____	Have steps been taken?/Date_____		
Date_____	Time of injury_____	Staff reporting _____	Child's Name_____
Child Age_____	What happened to cause injury?_____		
Where did it happen?_____	Suggested prevention steps_____		
_____	Have steps been taken?/Date_____		

Parental Request for Medication

Please note: Medications shall be given to children only with signed, written permission. Permission shall contain date, type, drug name, time and dosage. It shall be in the original container, not have an expired date, and labeled with the appropriate child's name. Dosages greater than specified on the label shall not be given.

Child's Name _____ Date _____

_____ has my permission to administer
(Name of Child Care Facility)
the following medication:

Drug name and or prescription# _____

Dosage to be given _____ Time(s) to be given _____

Special Instructions _____

(Parent/Guardian Signature & Date)

*** Person administering medication shall record time given and intial.				
Monday	Tuesday	Wednesday	Thursday	Friday

Staff Acknowledgement of Orientation

"I have read and/or been oriented to _____
(Facility Name)

policies and procedures. I agree to comply with them. I have reviewed the Minimum Licensing Requirements, and I agree to comply with them. I have been oriented to the fact that I am a mandated reporter of suspected child maltreatment under Arkansas Law (Act 1208 of 1992, amended). I have been provided with the necessary information to carry out such reporting.

I have been oriented to the basic health and safety procedures including emergency drills. I have also been instructed in the use of the fire extinguisher."

Witness _____

Employee _____

Date _____

Date _____

Personal Reference Check

Re: _____

—

Contact: _____
Name Address Phone

This is _____ With _____
(your name) (Name of center)

(Applicant) has applied with us for a job as _____
and has listed you as a personal reference. We have his/her authorization to contact
you for this reference.

1. How long have you known him/her?
2. In which of the following capacities do you know him/her: ___ Friend, ___ Co-worker,
___ Other. If other then please describe the capacity in which you know him/her.
3. Do you have any personal knowledge of how s/he relates to children and they relate
to him/her? If so, please describe what you have seen and heard.
4. Do you have any knowledge of the discipline practices used by him/her? If so, what
have you viewed?
5. Would you recommend him/her to work in a child care facility?
6. Is there anything else you would think we should know?

Signature of Interviewer

Date

Child Maltreatment Reporting Form

Person receiving report: _____ Date _____ Time _____

Child's Name _____ DOB _____ Sex Male/Female Race _____

Child's Address _____

Name(s) of Parent(s): _____

Phone Numbers: Home _____ Work _____

Phone Numbers: Home _____ Work _____

Parent(s) Address: _____

Physical indicators observed and when: _____

Behavioral indicators observed and when: _____

Other indicators observed/when: _____

If known, name and address of person responsible for maltreatment: _____

Source of report: _____

Action taken by reporting source: _____

Parents informed of report being made? _____ Yes _____ No

Reporter's name and position: _____

Daily Schedule

Please list the time you start accepting children, the times and types of activities you plan for the children (including outside activities), snack times, meal times, nap times, and departure.

Signature

Date

Facility Name and Address

Sample Safety Check List
(This list is not complete. Use as a guide only!)

Time of Inspection _____

	Yes	No	N/A	Notes
BUILDING				
Heating/Cooling source guarded/safe				
Temp/ventilation adequate				
Clean/Hazard Free				
GROUNDS				
Equipment safe				
Environment Safe				
Age Appropriate				
FURNITURE				
Equipment Appropriate/Adequate/Accessible/Safe				
Cots/Mats Appropriate				
Top/Bottom Cover				
Baby Beds/Playpens Appropriate				
Baby Beds/Playpens meet safety requirements				
HEALTH				
1st aid supplies:Band-aids, scissors, roll & Square gauze Antiseptic, thermometer, and tape				
Medication Locked				
Bathroom: Towels/soap/ toilet paper				
SAFETY				
Poisonous substances locked				
Detergent/Cleaning Supplies out of reach				
Smoke detectors/fire extinguisher				
Outlets Guarded				
TRANSPORTATION				
Vehicle: Adequate seating/ safety devices				

Signature of Staff Completing Check

Date

TRAINING RECORD

Facility _____

License Year _____

Staff Name	Title of Training	Date	Clock Hours	Presenter
1.	1.			
	2.			
	3.			
	4.			
	5.			
2.	1.			
	2.			
	3.			
	4.			
	5.			
3.	1.			
	2.			
	3.			
	4.			
	5.			
4.	1.			
	2.			
	3.			
	4.			
	5.			
5.	1.			
	2.			
	3.			
	4.			
	5.			