New Leaf

PRESCHOOL

ENROLLMENT PACKET

Each of these forms is required for enrollment
and must be turned in to the office no later than the night of "Meet your Teacher" or your studio sit-in.

ENROLLMENT CONTRACT

Child Information

Name	
Address	
City / State / Zip	
Date of Birth / Due Date	
Male / Female	
Program Applying For	
Start Date	

Parent / Guardian Information

Mother's Full Name	
Address	
City / State / Zip	
Home Phone	
Cell Phone	
Employer	
Work Address & Phone	
Email	

Father's Full Name	
Address	
City / State / Zip	
Home Phone	
Cell Phone	
Employer	
Work Address & Phone	
Email	

Enrollment Information

Education Services Needed	☐ School Day ☐ Before School ☐ After School
Studio Level (Grade)	

Additional Information

How did you hear about NLP?	

Educational Fees

Child's Name		Before &/or After School Care	
		Meals & Snacks	
Child's Name		Before &/or After School Care	
		Meals & Snacks	
Child's Name		Before &/or After School Care	
		Meals & Snacks	
		Total:	

By signing below I agree to and understand everything in this enrollment packet and agree to pay the above educational fees monthly one month in advance. I acknowledge that any upfront fees paid including but not limited to supply fees, tuition, and offsite trip fees are non-refundable and non-prorated.

By signing below I agree to all of the school policies including but not limited to those in the handbook and understand that I am to provide a four week written notice of intent to withdraw children and I am required to pay any fees associated with those four weeks whether or not children continue to attend.

By signing below I agree and understand to pay any fees applicable that are outlined on the second page of the rate sheet.

_____ _____

Signature Date

WHAT TO BRING

INFANT STUDIO

Diapers (Cloth or Disposable)
Baby Wipes
Diaper Cream
Labeled Blanket
Swaddle Blanket with Velcro or Sleep Sac if used
Labeled Pacifier
5 bottles
3 labeled full changes of clothes

EMERGENT TODDLER STUDIO

Diapers (Cloth or Disposable)
Baby Wipes
Diaper Cream
Labeled Cot Mat & Blanket
Comfort Item (ex. Stuffed animal) if used
Pacifier if used
3 labeled full changes of clothes
Mineral Sunscreen
Insect repellent (DEET free)
Outdoor play clothing suitable for season (Shade hat, coat, winter hat, mittens, etc.)
Labeled water bottle

TODDLER STUDIO

Diapers or pull-ups
Wipes & Diaper Cream
Labeled Cot Mat & Blanket
Comfort item (ex. Stuffed animal) if used
3 full changes of clothes
Mineral Sunscreen
Insect repellent (DEET free)
Outdoor play clothing suitable for season (Shade hat, rubber boots, coat, winter hat etc.)
Labeled water bottle
Backpack (large enough to fit their take-home folder)
Program fee

JUNIOR KINDERGARTEN STUDIO

Please refer to the yearly supply list on our website

HEALTH HISTORY AND EMERGENCY CARE PLAN

Child's Name	
Child's Birthday	

Medical Conditions

Please check any special medical conditions that your child may have:

No specific medical conditions
Asthma
Cerebral Palsy/ Motor Disorder
Diabetes
Epilepsy/ Seizure Disorder
Gastrointestinal or feeding concerns including special diet and supplements
Any disorder including Cognitively Disabled, LD, ADD, ADHD, or Autism
Other condition(s) requiring special care- Specify:
Milk Allergy. If a child is allergic to milk attach a statement from the medical professional indicating the acceptable alternative. Milk Alternatives must be supplied and come labeled with the students first and last name.
Food Allergies- Specify food(s):
Non-Food Allergies- Specify:

Triggers that may cause problems- Specify:
Signs or symptoms to watch for- Specify:

Steps the child care provider should follow: (If prescription or non-prescription medications are necessary, a copy of the form Authorization to Administer Medication should be attached to this form)
Identify any child care staff to whom you have given specialized training/ Instructions to help treat symptoms: a. b. c.
When should parents be called regarding symptoms or failure to respond to treatment?
When should it be considered that the condition requires emergency medical care or reassessment?
Additional information that may be helpful to the child care provider:

_____ _____

Signature- Parent or Guardian Date Signed (mm/dd/yyyy)

Review Dates: _____ _____ _____ _____ _____

(mm/dd/yyyy)

EMERGENCY CONTACT(S)

The top two individuals are typically the Mother & Father or child's legal guardians

Name	
Relationship to Child	
Address	
City/ State/ Zip	
Home or Cell Phone	
Work Phone	
Authorization to Pick up your Child?	

Name	
Relationship to Child	
Address	
City/ State/ Zip	
Home or Cell Phone	
Work Phone	
Authorization to Pick up your Child?	

Additional individuals Authorized to pick up your child:

Name	
Relation to Child	

Name	
Relation to Child	

Name	
Relation to Child	

Name	
Relation to Child	

PHOTO RELEASE FORM

By signing this photo release form I give New Leaf Preschool and Prep Academy permission to post photos and videos that may contain my child in any of the following locations:

- The New Leaf Facebook Pages
- On the New Leaf Websites
- On the New Leaf's Instagram Pages
- On classroom sharing applications such as Brightwheel
    - (NLPA Parent & Teacher only viewing)

_____ _____

Signature Date

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

dcf.wisconsin.gov/

CHILD HEALTH REPORT – CHILD CARE CENTERS

Use of form: Use of this form is voluntary; however, completion of this form meets the requirements of DCF 202.08(4), DCF 250.04(6)(a)4. and DCF 251.04(6)(a)8. Failure to comply with these rules may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: Each child under 2 years of age shall have an initial health examination not more than 6 months prior to nor later than 3 months after being admitted to the center and a follow-up health examination at least once every 6 months thereafter. Each child 2 years of age but who is not 5 years of age or older shall have an initial health examination not more than one year prior to nor later than 3 months after being admitted to a center and a follow-up health examination at least once every 2 years thereafter. The parent / guardian shall give this form to the physician, physician assistant, or other EPSDT provider to be completed, signed, and dated. The licensee / operator shall obtain a copy for the child's record. Note: Children are also required to have on file at the child care center documentation of immunizations; it may be helpful if the parent / guardian includes a copy of the child's immunization record when submitting this form to the child care center.

PARENT OR GUARDIAN – This section should be completed by the parent or guardian

Child's Name (Last, First, MI)	Child's Birthdate (mm/dd/yyyy)

Child's Address (Street, City, State, Zip Code)

Parent or Guardian Name (Last, First, MI)

Parent or Guardian Address (Street, City, State, Zip Code)

HEALTH PROFESSIONAL – This section should be completed by the health professional

Instructions for feeding and care of child with special health concerns – Specify: (attach information as necessary).

☐ Yes ☐ No Does the child have a milk allergy? If "Yes," identify the recommended milk substitute.

☐ Yes ☐ No Does this child have any food or non-food allergies? If "Yes," specify and include the treatment plan to be implemented in the event of an allergic reaction.

Date of child's most recent blood lead test: _____ (mm/dd/yyyy).
Note: Children on Medicaid are required to be tested at around ages 12 months and 24 months or once between the ages of 3 and 5 years if no previous test is documented. Lead testing is optional for children who are not on Medicaid.

Immunization(s) not to be administered to child due to medical reason(s) – Specify.

AUTHORIZATION

I certify that I have examined the above child on this date and that he / she is able to participate in child care activities.

Name – MD, PA, or other EPSDT Provider (type or print)	Address (Street, City, State, Zip Code)

SIGNATURE – MD, PA, or other EPSDT Provider	Date of Examination

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44192 (Rev. 12/2017)

STATE OF WISCONSIN
Wis. Stat. § 252.04

CHILD CARE IMMUNIZATION RECORD

COMPLETE AND RETURN TO CHILD CARE CENTER. State law requires all children in child care centers to present evidence of immunization against certain diseases within **30 school days (6 calendar weeks) of admission to the child care center.** These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the child care center. See "Waivers" below. If you have any questions about immunizations, or how to complete this form, please contact your child's child care provider or your local health department.

PERSONAL DATA **PLEASE PRINT**

STEP 1

Child's Name(Last, First, Middle Initial)	Date of Birth (Month/Day/Year)	Area Code/Telephone Number
Name of Parent/Guardian/Legal Custodian (Last, First, Middle Initial)	Address (Street, Apartment number, City, State, Zip)	

IMMUNIZATION HISTORY

STEP 2

List the MONTH, DAY AND YEAR the child received each of the following immunizations. DO NOT USE A (√) OR (**X**) except to indicate whether the child has had chickenpox. If you do not have an immunization record for this child, contact your doctor or local public health department to obtain the records.

TYPE OF VACCINE	First Dose Month/Day/Year	Second Dose Month/Day/Year	Third Dose Month/Day/Year	Fourth Dose Month/Day/Year	Fifth Dose Month/Day/Year
Diphtheria-Tetanus-Pertussis (Specify DTP, DTaP, or DT)					
Polio					
Hib (Haemophilus *Influenzae* Type B)					
Pneumococcal Conjugate Vaccine (PCV)					
Hepatitis B					
Measles-Mumps-Rubella (MMR)					
Varicella (chickenpox) vaccine Vaccine is required only if the child has not had chickenpox disease.					

Has the child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known.

☐ Yes year _____ (Vaccine is not required)

☐ No or Unsure (Vaccine is required)

REQUIREMENTS

STEP 3

The following are the minimum **required** immunizations for the child's age/grade at entry. All children within the range must meet these requirements at child care entrance. Children who reach a new age/grade level while attending this child care must have their records updated with dates of additional required doses.

AGE LEVELS	NUMBER OF DOSES						
5 months through 15 months	2 DTP/DTaP/DT	2 Polio	2 Hib	2 PCV	2 Hep B		
16 months through 23 months	3 DTP/DTaP/DT	2 Polio	3 Hib[1]	3 PCV[2]	2 Hep B	1 MMR[3]	
2 years through 4 years	4 DTP/DTaP/DT	3 Polio	3 Hib[1]	3 PCV[2]	3 Hep B	1 MMR[3]	1 Varicella
At Kindergarten entrance	4 DTP/DTaP/DT[4]	4 Polio			3 Hep B	2 MMR[3]	2 Varicella

[1] If the child began the Hib series at 12-14 months of age, only 2 doses are required. If the child received one dose of Hib at 15 months of age or after, no additional doses are required. Minimum of one dose must be received after 12 months of age (Note: a dose 4 days or less before the first birthday is also acceptable).

[2] If the child began the PCV series at 12-23 months of age, only 2 doses are required. If the child received the first dose of PCV at 24 months of age or after, no additional doses are required.

[3] MMR vaccine must have been received on or after the first birthday (Note: a dose 4 days or less before the 1st birthday is also acceptable).

[4] Children entering kindergarten must have received one dose after the 4th birthday (either the 3rd, 4th or 5th) to be compliant (Note: a dose 4 days or less before the 4th birthday is also acceptable).

COMPLIANCE DATA AND WAIVERS

STEP 4

IF THE CHILD MEETS ALL REQUIREMENTS (sign at STEP 5 and return this form to the child care center), OR

IF THE CHILD **DOES NOT** MEET ALL REQUIREMENTS (check the appropriate box below, sign and return this form to child care center).

☐ Although the child has not received all required doses of vaccine for his or her age group, at least the first dose of each vaccine has been received. I, understand that it is my responsibility to obtain the remaining required doses of vaccines for this child **WITHIN ONE YEAR** and to notify the child care center in writing as each dose is received.

NOTE: Failure to stay on schedule or report immunizations to the child care center may result in court action against the parents and a fine of up to $25.00 per day of violation.

☐ For health reasons this child should not receive the following immunizations _____(List in STEP 2 any immunizations already received)

_____
Physician's Signature Required

☐ For religious reasons this child should not be immunized. (List in STEP 2 any immunizations already received)

☐ For personal conviction reasons this child should not be immunized. (List in STEP 2 any immunizations already received):

SIGNATURE

STEP 5

To the best of my knowledge, this form is complete and accurate.

_____ _____

SIGNATURE - Parent, Guardian or Legal Custodian Date Signed