

Little Cupcakes Child Care

215 Edgewood Rd SW
Cedar Rapids, Iowa 52404
Phone: (319) 363-1413

Contract for Services

This is a contract between _____ and Little Cupcakes
(Name of Parent(s)/Guardian(s))

Child Care. Childcare services provided for _____ on the days and hours
(Name of Child)
listed below. These times **are not** flexible.

Monday from _____ am to _____ pm

Tuesday from _____ am to _____ pm

Wednesday from _____ am to _____ pm

Thursday from _____ am to _____ pm

Friday from _____ am to _____ pm

This contract is effective from _____ through _____.
(Date) *(Date)*

The contracted fee will be \$ _____ per week payable in advance on Friday, before the first attendance day of the week and a \$35.00 registration fee per family.

All payments are due the Friday before the week of child care provided. If payment is not received on time per contract, there will be a \$10.00 **per day** late fee. You will be required to pay for the week that is late and all late fees with the next week's payment. If payments aren't received as stated above, the contract of services will be terminated. NOTE: We are only permitting you to fall one week behind.

Families that are on government assistance, you are allowed four absence days **per month**. All holiday closings count toward your four days. Keep that in mind when your child is absent from child care. **If you go over those four days in a month's time, you are responsible for the daily rate for each day missed.**

A two-week written notice is required for withdrawal from the center, and is to be given to the Center Director. Payment is expected for the two-week period. If the child(ren) leave before the two week period, payment is still expected for the complete two weeks. If we do not receive a two week notice, you are still responsible for a two week notice fee.

Additional fees are: \$1/minute past your 10 hours, \$1/minute past 5:30pm and \$2/minute if you are past your 10 hours and past 5:30pm. This fee is per child rate. If this becomes a recurring habit, this contract will be terminated and you will be responsible for the two week notice fee also.

Private Pay Families: You are responsible for 100% full weekly rate, present or absent, during your first year. After your first completed year, each family will be granted 50% rate reduction for one week vacation or 5 consecutive days due to illness. Any additional days, will be charged 100% full rate. Each year following at Little Cupcakes Child Care, you will be granted 1 week FREE for vacation or 5 consecutive days due to illness. Any additional days, will be charged 100% full rate.

Signature of Parents(s) or Guardian(s)

Date

Email Address

Your invoices will be through email. Please make sure and check them often. Thank you.

July 5, 2018

Little Cupcakes Child Care
Parental Emergency Medical Consent Form

Child's Name: _____ Date of Birth: _____

PARENTS/GUARDIANS (Minimum of One Person)

Name _____ Relationship _____

Address _____

Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

Name _____ Relationship _____

Address _____

Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

EMERGENCY CONTACTS (Minimum of Two People)

Name _____ Relationship _____

Address _____

Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

Name _____ Relationship _____

Address _____

Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

Name _____ Relationship _____

Address _____

Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

Are there any custody or restraining orders in effect that we should be aware of? If so, please explain and list the people involved that **MAY NOT** pick up your child: _____

PHYSICIANS/DENTISTS/HOSPITAL

Child's Doctor *Phone* *Complete Address*

Child's Dentist *Phone* *Complete Address*

Hospital *Phone* *Complete Address*

Known allergies *Present Medications* *Date of last tetanus*

In the event that my child (listed above) may require medical and/or surgical care while I am unable to be reached, I hereby give my consent to medical and/or surgical treatment at: _____. (LIST HOSPITAL) I agree to pay all costs and fees contingent on any emergency medical care and/or treatment of my child as secured or authorized under this consent. **Note:** Every effort will be made to notify parents/guardians immediately in case of emergency.

Signature _____ Date _____

Signature _____ Date _____

**Little Cupcakes Child Care
Intake Sheet**

Infants and Toddlers

Has your baby had any feeding problems? Yes ___ No ___

If yes, explain _____

For any allergies or sensitivities to particular foods: Please ask for a diet modification sheet!

Baby is taking (Circle One) Breast Milk Members Mark Advance Members Mark Sensitive Other _____
(Members Mark is equivalent to Similac. We provide Members Mark)

How often? _____ How many ounces? _____

Sleep habits during the day: _____

Do you have special ways of helping your baby go to sleep? If yes, how? _____

Other Information

What do you hope your child will gain from this experience? _____

Please list some of your child's favorites:

Snacks & Drinks: _____

Games: _____

Other Activities: _____

Give any other information you believe will be helpful to us in working with your child. _____

Thank you for completing the enrollment information. This helps us become acquainted with your family and your child's needs so that we can provide the quality care that you deserve. Please update us of any changes in the above information and of any changes that affect your child's health or adjustment here at our center. Please feel free to ask any questions as we want to be the best partners possible in caring for your child.

Amanda Schutte, Director
Little Cupcakes Child Care

Payment

I (we) are responsible for paying the child care bill every Friday.

Signature _____ Date _____

Little Cupcakes Child Care

Intake Sheet

Physical Regime

Does your child have any unusual eating problems or food dislikes? *If so, explain* _____

What is your child's usual waking time? _____ What is your child's usual bed time? _____

Is your child toilet trained? Yes ___ No ___

How does he/she state their need? _____

Has your child ever had an ear or hearing examination or treatment? _____

When? _____ By whom? _____

Results? _____

Has your child ever had a vision or hearing examination or treatment? _____

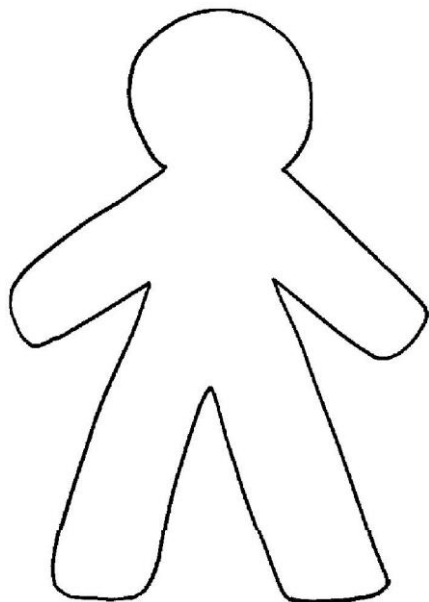
When? _____ By whom? _____

Results? _____

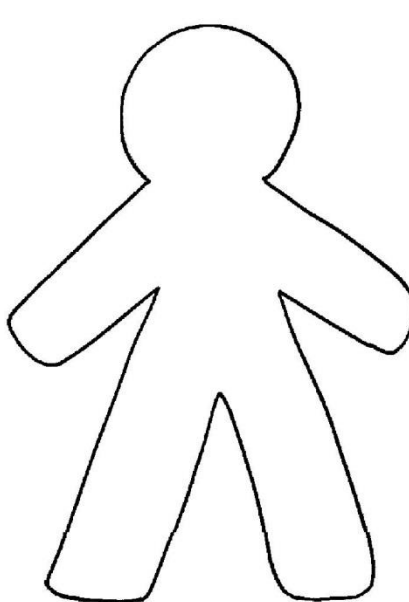
Has your child been diagnosed with any special needs? If yes, what? _____

Please indicate any permanent body markings (birthmarks, mongolian spots, scars, etc.) on the images below.

Front



Back



Play and Social Skills

How does your child get along with other children? _____

How does your child get along with adults? _____

What is the size and type of previous group experiences your child might have had? _____

Personality and Emotional Development

Is your child affectionate? Yes ___ No ___

Does he/she accept new people and experiences easily? Yes ___ No ___

What are your child's fears? _____

**Little Cupcakes Child Care
Release Authorization**

Photography/Videotaping Release

Our Center is under 24 hour surveillance. Please initial your name to permit for the following:

_____ *Yes, I grant permission to use photos of my child on Little Cupcakes Child Care Website.*

_____ *Yes, I grant permission to use photos of my child on Little Cupcakes Child Care Facebook.*

_____ *Yes, I grant permission to use photos of my child on Little Cupcakes Child Care Classroom.*

_____ *No, Please do not take or use any photos of my child.*

Restrictions:

Date

Signature of Parent or Legal Guardian

Sunscreen Release

I give permission for my child (name of child) _____ to have sunscreen applied before outdoor activities by the center staff at Little Cupcakes Child Care. I/We are responsible for providing sunscreen for our child's individual use.

Restrictions:

Date

Signature of Parent or Legal Guardian

Walk Release

When weather permits, I give permission for my child, _____ to go for a walk around the neighborhood. I understand the Infant and Toddler Rooms have a four seat stroller that each child is buckled in.

Restrictions:

Date

Signature of Parent or Legal Guardian

Bouncy House Release

I give permission for my child (name of child) _____ to participate in the bouncy house activity, indoors or outdoors.

Restrictions:

Date

Signature of Parent or Legal Guardian

**Little Cupcakes Child Care
Pick-Up Authorization Form**

Childs Name _____ Childs Age _____

I hereby give permission for my child to leave the center with the following persons identified below. It is my responsibility to notify the center in writing of any changes to this authorization. **Note:** A photo ID will be required for any person(s) to pick up your child.

Name	Address	Phone #	Relationship to Child
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Persons that are not listed on the Parental Emergency Medical Consent Form or the Pick-Up Authorization Form will not be able to pick up child.

The only circumstance that we can prevent a parent/guardian of a child from picking the child up is to have a court order prohibiting contact with the child.

Is there a court order prohibiting contact with my child by any person?

Yes ___ No ___ If 'Yes' please provide photocopy of order.

Name of prohibited person _____ Relationship _____

Is there any child custody order of which we need to be aware? _____

If so, please advise: _____

Signature of Parent or Guardian

Date