



Center of Excellence
810 South 7th Street
Minneapolis, MN 55415
612-249-5337

Application for Child Care Services

Thank you for your interest in attending the Center of Excellence! We are excited for your family to join ours and we look forward to walking next to you in your journey as your child grows during the incredible and fulfilling years. There are a few steps to complete before we can officially choose a start date for your family. Please read the four requirements below and if you need assistance or have any questions, feel free to talk with a director. As soon as these steps are complete we can plan your families first day!

Sincerely,

The Center of Excellence Directors

Steps to Enroll

Step 1: Fill out the enrollment application and turn it into or fax it to a director

Step 2: Confirm method of payment (private pay, county assistance, scholarship)

Step 3: Turn in the 2 medical records from your clinic (your child's Immunizations, and Health Care Summary, your clinic can fax the records over to us)

Step 4: Set up a tour/meeting with your child's teacher so meet and talk about your child

FAX NUMBER: 612.353.4599

Documents Needed

Center of Excellence Enrollment Packet (complete and turn in)

Health Care Summary (give to clinic and turn in completed copy with packet)

Child Immunization Records (give to clinic and turn in completed copy with packet)

Revised 8/15/2023

Meet My Child

Name _____ Date of Birth _____ Classroom _____

Parent/Guardian _____ and _____

Race: American Indian/Alaska Native Asian/Pacific Islander Black/African-American White/Caucasian Hispanic
 African European Multiracial/not of Hispanic origin

Is this your child's first experience in child care? Yes No

Other members of the household:

_____ Relation to child _____

_____ Relation to child _____

_____ Relation to child _____

_____ Relation to child _____

Health

Has your child ever been hospitalized, if so for what? _____ When? _____

Does your child use medication? No YES When? _____

Special Conditions	Treatment
Allergies to:	
Asthma when:	
Seizures when:	
Rashes:	
Does your child have an Individual Education Plan and/or receiving special services? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Other:	

There are concerns about:

Vision Hearing Development Speech Growth Behavior

Other _____

Toilet Training

Is your child: Totally independent
 Mostly independent
 Needs some help

Words used when referring to toileting

Urination: _____

Bowel Movement: _____

Personality

The words to best describe my child are:

What would you like to tell us about your child? _____

Description of child eating, sleeping, toileting, and communication habits (For children 6 weeks-36 weeks)

How is your child best comforted?

Held Given space Talked to/with Redirected Other _____

Activities your child enjoys:

Books Music Pretend Play Physical Exercise Blocks/Legos Other _____

What would you like your child to learn and experience at our center?

Culture

What events, holidays, or observations does your family participate in?

Hanukah New Year's Christmas Kwanza Halloween Thanksgiving

Others days or customs practiced _____

What language does your family speak at home? _____

Is there something in your family's culture you would like us to be aware of and/or bring to the center?

Parent Participation

How would you like to participate in our program?

Field Trips Classroom Volunteer Family Fun Nights Sharing your hobby or interest

Share your career with the class Parent-Teacher Conferences (Twice a year)

Other ideas or family culture opportunities _____

Emergency Information

Child's Name: _____ D.O.B: _____ Age: _____ M F

Address: _____ City: _____ State: _____ Zip: _____ County: _____

Parents Name: _____ Main Number: _____ Other: _____

Place of work/School: _____ Cell Work Home Cell Work Home

Parents Name: _____ Main Number: _____ Other: _____

Place of work/School: _____ Cell Work Home Cell Work Home

Other Authorized Pickups and Emergency Contacts

Name: _____ Number: _____ Relationship: _____

Cell Work Home

Address: _____

Name: _____ Number: _____ Relationship: _____

Cell Work Home

Address: _____

Name: _____ Number: _____ Relationship: _____

Cell Work Home

Address: _____

Medical Information

Child's Physician/Doctor: _____ Phone: _____

Address: _____ Preferred Hospital: _____

Regular/Emergency Dental: _____ Phone: _____ Address: _____

Drug Allergies: _____ Food/Other Allergies: _____

Current Medication: _____ Other Medical Concerns: _____

Other Medical Information: _____

- I give permission to The Center of Excellence to take whatever emergency measures they judge necessary for the care and protection of my child while under their supervision.
- In case of a medical emergency, I understand that my child will be transported to an appropriate medical

facility by the local emergency unit (911).

- I understand that in some medical situations, the staff will need to contact the local emergency unit before calling the parent. They will try all emergency contacts listed if necessary.
- If a Parent/Guardian cannot be reached or is delayed in arriving in a medical emergency, I authorize the Center of Excellence to find emergency care for my child. I accept responsibility for cost not covered by insurance.

What is your preferred way to communicate?

- BrightWheel Message
- Phone Call
- Email
- Letter/note sent home

Information and Permissions

Parent's Name's _____ & _____

Email _____ Email _____

Preferred way of contact: Phone Brightwheel App Email

Are you currently receiving or in the process of receiving Childcare Assistance? Yes No

What type? Think Small Scholarship County Assistance

Case Number _____ County _____

County Worker Name: _____ Phone _____

Job Counselor Name: _____ Phone _____

Schedule (hours your child will be with us)

How did you hear about our Center?

- Internet Search
- Google
- Care.com
- Case worker/job counselor
- Flyer/Brochure
- Outside Sign
- Word of Mouth
- Our Website
- Friend/Acquaintance

Monday:

Tuesday:

Wednesday:

Thursday:

Friday:

PERMISSIONS

- My child has permission to go on neighborhood walks within 0.6 miles of the Center
- I give staff at The Center of Excellence permission to use as needed: sunscreen, bug spray, lip balm, diaper cream/ointment, diaper wipes, and will provide these products for my child. (No spray cans, please)
- I give my permission for the center to use anonymous pictures/media for center use, printed materials, and social media. (if you do not want this do not check the box)
- I understand that for every minute after 6pm that my child/children are not picked up I will be charged \$3. If I do not pay this fee I am at risk for losing my spot, and if I am not able to pay this fee I will request a meeting with a director.
- I give the Center of Excellence permission to give my child assessments for conferences and tracking age appropriate development.

Signature: _____ **Date:** _____