



Kids Klub Bellevue

Infants ☆ Preschool ☆ School Age

Dear Parents,

Welcome to Kids Klub Child Development Centers! Enclosed, is a membership application packet containing important information. At Kids Klub, we have a mutual concern for the well being of your child. These forms will help us to understand your child better and allow us to provide him/her with the proper care. Please complete and return them to us as soon as possible along with the one-time, non-refundable enrollment fee per child of either \$250.00 (weekdays) or \$50.00 (evenings & weekends) per child.

Because we are required by the Washington State Department of Children, Youth and Families to have completed records on all children, we ask that you take the time to fill out the attached documents completely and accurately.

ONLY COMPLETED APPLICATIONS WILL BE ACCEPTED. IF A REQUIRED DOCUMENT IS MISSING, YOU WILL BE ASKED TO HANG ON TO THE APPLICATION UNTIL ALL COMPLETED DOCUMENTS CAN BE HANDED IN TOGETHER WITH THE NON-REFUNDABLE INITIATION FEE. **EXCEPTION IS MADE FOR UNBORN INFANTS TO BE PLACED ON WAITING LIST ONLY

All Children:

- Enrollment Application & Parent Information
- Membership Contract & Payment Method
- Health History and Emergency Information
- Field Trip / Sunscreen / Photo Permission
- Infant or Child's Needs Form
- UPDATED Certificate of Immunization Status

School Age (After School & Camp) Only:

- After School Contract OR Camp Registration **(NOT INCLUDED IN PACKET)**

For children starting our Evening/Weekend Program: Once your completed application has been received, you may start using us within 24 hours. Pending certain circumstances, you may be asked to attend an Orientation for the Evening/Weekend Program prior to acceptance.

For children starting one of our Weekday Programs: A Parent Orientation is required with you to discuss any particular needs your child may have. An appointment will be made for your family 1-3 weeks prior to your start date. Please be prepared to pay for your first month's tuition at that time. You may start using the Evening/Weekend program within 24 hours of your completed application has been received.

Please read the Membership Handbook thoroughly to understand all of the Kids Klub Policies & Procedures. If you have any questions, we will be happy to answer them.

Leslie Buettner
Center Wide Director

Kids Klub Bellevue

Early Bird Evening / Weekend Membership

Kids Klub Bellevue will be open on evenings and weekends. We are here to care for your children during the hours when other childcare facilities are closed.

Special Early Bird Offer available exclusively for "Evening/Weekend Only" families that sign up prior to opening date.

Cost: \$50.00 per child (Fully Refundable - See Below for Details)

1. The \$50 is fully refundable at any time by contacting Kids Klub prior to 90 days after our opening date, as long as no childcare services have been provided.
2. A \$25 Gift Card: A \$25 Gift Card will be given to you for Evening/Weekend child care that can be used after opening with no expiration date. (Net cost per child for evening weekend membership is \$25 per child instead of \$50).

Note: For each child in the family a fully completed application will need to be completed and a \$50 payment will need to be made to benefit from the Early Bird Evening Weekend Membership.

Kids Klub Bellevue

ENROLLMENT APPLICATION

Today's date: _____

Referred By: _____

Main Billing Address: _____, WA _____
(Street) (City) (Zip)

Membership	Age Group	Services Desired (check all that apply)
Early Bird Evening/Weekend Membership	Infant/ Toddler (4 weeks 29 mos) Preschool (30mos - PreKindergarten) School Age (Kinder - up to 13 years)	

Please complete and return the following application form and include the \$250 Non-Refundable Enrollment Fee per child (see previous page for details), or the \$50.00 per child for Evening/Weekend members. These fees cover administrative costs for establishing a membership, as well as costs for earthquake kits, mats, sheets, etc. We look forward to being able to meet your childcare needs.

CHILD'S INFORMATION

Shaded area to be filled in by Kids Klub

First Name	Last Name	Birth Date	Sex	Soc. Sec #	Program Code	Days of the Week	Lunch	Start Date
						M Tu W Th F	Y N	

MOTHER'S INFORMATION

Name: _____
 Address: _____
 (if Different from _____, WA _____
 Address) (City) (Zip)
 Employer: _____
 Occupation: _____
 Address: _____
 _____, WA _____
 (City) (Zip)

Contact Information:
 Home: () - -
 Work: () - -
 Cell: () - -
 Email: _____
 Soc. Sec #: - -
 Drivers Lic: _____

FATHER'S INFORMATION

Name: _____
 Address: _____
 (if Different from _____, WA _____
 Address) (City) (Zip)
 Employer: _____
 Occupation: _____
 Address: _____
 _____, WA _____
 (City) (Zip)

Contact Information:
 Home: () - -
 Work: () - -
 Cell: () - -
 Email: _____
 Soc. Sec #: - -
 Drivers Lic: _____

**FORM REQUIRED
FOR ALL CHILDREN**

MEMBERSHIP CONTRACT & PAYMENT METHOD

AGREEMENT TO FOLLOW KIDS KLUB POLICIES

My signature below certifies that I have read, understand and agree to all of the conditions and policies (pre-admission, Admissions and fees) of a Kids Klub Membership. I understand that Kids Klub reserves the right to refuse membership or terminate an existing membership to anyone whom does not comply with our Policies as outlined in the Membership Handbook.

Failure by the provider to enforce one or more terms of the contract does not waive the right of the provider to enforce any other terms of the contract.

X

PARENTS NAME

PARENT/GUARDIAN SIGNATURE

DATE

PAYMENT METHOD

Standard Payment Method:

- Tuition will be paid by /ACH withdrawal (see below), PayPal, cash or money order on the 1st of each month. I understand that a late charge of \$25.00 will be added to my account if payment is not received by the 10th of each month. All returned checks will be charged a \$10.00 returned check fee.

Optional Automatic Withdrawal Payment Method:

If you would like your tuition automatically withdrawn from your checking account or credit card each month, please fill out this section of the application. Your total monthly charges will be deducted on the 3rd of the month and you will receive a statement three weeks prior with the details of your charges and notifying you of the upcoming withdrawal. We accept MasterCard, Visa, Discover Cards & Amex.

- Tuition will automatically be charged to my credit card on the 3rd of each month:

(circle applicable credit card type) MasterCard Visa Discover Amex

Card Number: _____ Expiration Date: _____ CID: _____

3 OR 4 DIGIT CODE ON BACK

PRINT NAME ON CARD: _____

AUTHORIZED SIGNATURE: _____

OR

- Tuition will be automatically deducted from my checking account on the 3rd of each month.

**ATTACH VOIDED CHECK
OR DEPOSIT SLIP HERE**

AUTHORIZED SIGNATURE: _____

For office use only:

Initiation Fee Received: \$ _____ Date: _____ Check #: _____

First Payment Received: \$ _____ Date: _____ Check #: _____

**FORM REQUIRED
FOR ALL CHILDREN**

HEALTH HISTORY AND EMERGENCY INFORMATION

CONSENT FOR MEDICAL TREATMENT

As the parent, agency representative or legal guardian, I hereby give consent to Kids Klub CDC to seek all emergency dental or medical care prescribed by a duly licensed Physician (M.D.) Osteopath (D.O.) or Dentist (DDS) for

_____ This care may be given under whatever conditions are necessary to preserve the life, limb or well being of my dependent.

Child has the following medication/food allergies*: _____

X

PARENT/DOMESTIC PARTNER /GUARDIAN SIGNATURE

DATE

PHYSICIAN OR DENTIST TO BE CALLED IN EMERGENCY

DATE CHILD WAS LAST SEEN BY PHYSICIAN FOR A PHYSICAL EXAM: _____

PHYSICIAN /	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?
 CALL EMERGENCY HOSPITAL OTHER EXPLAIN : _____

NAMES OF PERSONS WHO MAY BE CALLED IN AN EMERGENCY AND ARE AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR GUARDIAN)

NAME	RELATIONSHIP	TELEPHONE

MEDICAL CONDITIONS / SPECIAL NEEDS / SPECIAL CIRCUMSTANCES

Does your child have any special health needs OR special circumstances that Kids Klub should be aware of? if Yes, please explain**:

Yes No

Kids Klub Child Development Centers are licensed by the State of Washington, DCYF. Some children with medical conditions, special health needs or special circumstances may not be able to be accommodated due to the nature of their individual situation. As such, any child that has a unique need or situation will need to be evaluated to determine if their needs can be met and that all licensing requirements are met. This applies for both day-time and Evening/Weekend programs.

*** IF YOUR CHILD HAS FOOD ALLERGIES YOU WILL BE REQUIRED TO FILL OUT ADDITIONAL ALLERGY FORMS TO COMPLETE FILE**

****IF YOUR CHILD HAS A MEDICAL CONDITION OR REQUIRES MEDICATION TO BE TAKEN AT SHOOOL YOU WILL BE REQUIRED TO FILL OUT A MEDICAL AUTHORIZATION FORM TO COMPLETE FILE**

**FORM REQUIRED
FOR ALL CHILDREN**



Certificate of Immunization Status (CIS)

Reviewed by: _____ Date: _____
 Signed COE on File? Yes No

Please print. See back for instructions on how to fill out this form or get it printed from the Washington State Immunization Information System.

Child's Last Name:	First Name:	Middle Initial:	Birthdate (MM/DD/YYYY):
I give permission to my child's school/child care to add immunization information into the Immunization Information System to help the school maintain my child's record.		Conditional Status Only: I acknowledge that my child is entering school/child care in conditional status. For my child to remain in school, I must provide required documentation of immunization by established deadlines. See back for guidance on conditional status.	
X _____ Parent/Guardian Signature Date		X _____ Parent/Guardian Signature Required if Starting in Conditional Status Date	

▲ Required for School • Required Child Care/Preschool	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY
Required Vaccines for School or Child Care Entry						
●▲ DTaP (Diphtheria, Tetanus, Pertussis)						
▲ Tdap (Tetanus, Diphtheria, Pertussis) (grade 7+)						
●▲ DT or Td (Tetanus, Diphtheria)						
●▲ Hepatitis B						
● Hib (<i>Haemophilus influenzae type b</i>)						
●▲ IPV (Polio) (any combination of IPV/OPV)						
●▲ OPV (Polio)						
●▲ MMR (Measles, Mumps, Rubella)						
● PCV/PPSV (Pneumococcal)						
●▲ Varicella (Chickenpox) <input type="checkbox"/> History of disease verified by IIS						
Recommended Vaccines (Not Required for School or Child Care Entry)						
COVID-19						
Flu (Influenza)						
Hepatitis A						
HPV (Human Papillomavirus)						
MCV/MPSV (Meningococcal Disease types A, C, W, Y)						
MenB (Meningococcal Disease type B)						
Rotavirus						

Documentation of Disease Immunity (Health care provider use only)		
If the child named in this CIS has a history of varicella (chickenpox) disease or can show immunity by blood test (titer), it must be verified by a health care provider.		
I certify that the child named on this CIS has:		
<input type="checkbox"/> A verified history of varicella (chickenpox) disease.		
<input type="checkbox"/> Laboratory evidence of immunity (titer) to disease(s) marked below.		
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Hepatitis B
<input type="checkbox"/> Hib	<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps
<input type="checkbox"/> Rubella	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Varicella
<input type="checkbox"/> Polio (all 3 serotypes must show immunity)		
▶		
Licensed Health Care Provider Signature		Date
▶		
Printed Name		

I certify that the information provided on this form is correct and verifiable.	Health Care Provider or School Official Name: _____ Signature: _____ Date: _____ If verified by school or child care staff the medical immunization records must be attached to this document.
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Instructions for completing the Certificate of Immunization Status (CIS): Print the from the Immunization Information System (IIS) or fill it in by hand.

To print with the immunization information filled in:

Ask if your health care provider's office enters immunizations into the WA Immunization Information System (Washington's statewide registry). If they do, ask them to print the CIS from the IIS and your child's immunization information will fill in automatically. You can also print a CIS at home by signing up and logging into MyIR at <https://wa.myir.net>. If your provider doesn't use the IIS, email or call the Department of Health to get a copy of your child's CIS: waisrecords@doh.wa.gov or 1-866-397-0337.

To fill out the form by hand:

1. Print your child's name and birthdate, and sign your name where indicated on page one.
2. Write the date of each vaccine dose received in the date columns (as MM/DD/YY). If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guides below to record each vaccine correctly. For example, record Pediarix under Diphtheria, Tetanus, Pertussis as DTaP, Hepatitis B as Hep B, and Polio as IPV.
3. If your child had chickenpox (varicella) disease and not the vaccine, a health care provider must verify chickenpox disease to meet school requirements.
 - If your health care provider can verify that your child had chickenpox, ask your provider to check the box in the Documentation of Disease Immunity section and sign the form.
 - If school staff access the IIS and see verification that your child had chickenpox, they will check the box under Varicella in the vaccines section.
4. If your child can show positive immunity by blood test (titer), have your health care provider check the boxes for the appropriate disease in the Documentation of Disease Immunity section, and sign and date the form. You must provide lab reports with this CIS.
5. Provide proof of medically verified records, following the guidelines below.

Acceptable Medical Records

All vaccination records must be medically verified. Examples include:

- A Certificate of Immunization Status (CIS) form printed with the vaccination dates from the Washington State Immunization Information System (IIS), MyIR, or another state's IIS.
- A completed hardcopy CIS with a health care provider validation signature.
- A completed hardcopy CIS with attached vaccination records printed from a health care provider's electronic health record with a health care provider signature or stamp. The school administrator, nurse, or designee must verify the dates on the CIS have been accurately transcribed and provide a signature on the form.

Conditional Status

Children can enter and stay in school or child care in conditional status if they are catching up on required vaccines for school or child care entry. (Vaccine series doses are spread out among minimum intervals, so some children may have to wait a period of time before finishing their vaccinations. This means they may enter school while waiting for their next required vaccine dose). To enter school or child care in conditional status, a child must have all the vaccine doses they are eligible to receive before starting school or child care.

Students in conditional status may remain in school while waiting for the minimum valid date of the next vaccine dose plus another 30 days time to turn in documentation of vaccination. If a student is catching up on multiple vaccines, conditional status continues in a similar manner until all of the required vaccines are complete.

If the 30-day conditional period expires and documentation has not been given to the school or child care, then the student must be excluded from further attendance, per RCW 28A.210.120. Valid documentation includes evidence of immunity to the disease in question, medical records showing vaccination, or a completed certificate of exemption (COE) form.

Reference guide for vaccine trade names in alphabetical order

For updated list, visit <https://www.cdc.gov/vaccines/terms/usvaccines.html>

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB	Hib	Fluarix	Flu	Havrix	Hep A	Menveo	Meningococcal	Rotarix	Rotavirus (RV1)
Adacel	Tdap	Flucelvax	Flu	Hiberix	Hib	Pediarix	DTaP + Hep B + IPV	RotaTeq	Rotavirus (PV5)
Afluria	Flu	FluLaval	Flu	HibTITER	Hib	PedvaxHIB	Hib	Tenivac	Td
Bexsero	MenB	FluMist	Flu	Ipol	IPV	Pentacel	DTaP + Hib +IPV	Trumenba	MenB
Boostrix	Tdap	Fluvirin	Flu	Infanrix	DTaP	Pneumovax	PPSV	Twinrix	Hep A + Hep B
Cervarix	2vHPV	Fluzone	Flu	Kinrix	DTaP + IPV	Prevnar	PCV	Vaqta	Hep A
Daptacel	DTaP	Gardasil	4vHPV	Menactra	MCV or MCV4	ProQuad	MMR + Varicella	Varivax	Varicella
Engerix-B	Hep B	Gardasil 9	9vHPV	Menomune	MPSV4	Recombivax HB	Hep B		

FIELD TRIP / SUNSCREEN / PHOTO PERMISSION

WALKING FIELD TRIP PERMISSION

- I hereby give Kids Klub CDC my consent and permission to take my child from the center on local walking field trips close to Kids Klub.
- I DECLINE to give Kids Klub CDC my permission for walking field trips.

In either case, you will always be notified of an upcoming remote field trip where the children will be transported from the center by van, bus or car. For each trip, you will receive details of the trip, and you will need to give your permission for each trip. Only children with signed authorizations will be allowed to go on field trips.

X

(CHILD'S NAME)

PARENT/DOMESTIC PARTNER /GUARDIAN SIGNATURE

(DATE)

SUNSCREEN PERMISSION

- I hereby give the staff of Kids Klub CDC permission to apply Kids Klub sunscreen on my child (see permission form for active ingredients and time of application). I understand that it is my responsibility to provide sunscreen for my child if there is any potential allergies known to Kids Klub sunscreens.
- I DECLINE to give Kids Klub CDC my permission for Sunscreen.

X

(CHILD'S NAME)

PARENT/DOMESTIC PARTNER /GUARDIAN SIGNATURE

(DATE)

PHOTOGRAPIC RELEASE PERMISSION

- Full Photo Permission: I hereby give Kids Klub CDC permission to use photographs of my child on the photo boards, website and/or in brochures, etc. I understand that these photographs will not be sold by Kids Klub, and that my child may appear individually or in a group setting. Other than on our hallway photo boards, the name of my child will not be published in conjunction with these photographs without additional written consent from the parent.
- Partial Photo Permission: I hereby give Kids Klub CDC permission to use the photographs of my child for in house use (photo boards, personal portfolios, holiday gifts) and **WiMLO Private** (just sent to parent's of child only).
- WiMLO Private:** Any group shots sent to the class parents involving a "private" child will be blurred out or not include the child. The "private" child's parents can received either group shots including the child and/or individual pictures of the "private" child – these will be sent exclusively to just the child's parents.
- I DECLINE to give Kids Klub CDC my permission for Photographs in any form.

X

(CHILD'S NAME)

PARENT/DOMESTIC PARTNER /GUARDIAN SIGNATURE

(DATE)

**FORM REQUIRED
FOR ALL CHILDREN**

KIDS KLUB INFANT & CHILD'S NEEDS

The purpose of this information is to help your caregiver have a better understanding of your child's history. The information contained on these pages will aid in planning for your child's individual needs.

Childs Name: _____ Child's Age: _____ Today's Date: _____

Date Child was last seen for a physical exam: _____

ALLERGIES ONLY: List all Foods / Medications / Environmental allergies-

Has an Epi-Pen been prescribed by a doctor for your Child?: YES NO

If Yes, please tell us what it has been prescribed for: _____

SPECIAL CIRCUMSTANCES: IE, FOOD PREFERENCES/DIETARY RESTRICTIONS, SPECIAL NEEDS, MEDICAL CONDITIONS, ETC: Please list any foods/drinks that you would like for Kids Klub to avoid feeding your child. This is for preferences only, not allergies, please list any true allergies above:

- Updated in Computer
 Allergy Paper Work Given to Parents _____ (initials)

PART A: FOR CHILDREN UNDER 30 MONTHS OF AGE – PLEASE SKIP TO PART B FOR 30+ MONTHS

INFANT INDIVIDUAL FOOD AND FEEDING PLAN:

We warm formula or breast milk in a bottle warmer. Our care giving staff wants to be able to greet each family and exchange information and check for any illness upon arrival.

Breastmilk/type of formula or combination of? _____

My child usually has a bottle about every _____ hours, and takes approximately _____ ounces.

Is your child on a special diet? YES / NO If yes, please describe _____

Is child on solid foods? YES / NO If yes, please describe _____

My child is normally COMFORTABLE / UNCOMFORTABLE after eating. If uncomfortable, I usually _____

My child's sleep schedule is as follows: _____

My child naps for approximately _____ hours/minutes between _____ & _____ a.m. and _____ & _____ p.m.

How does your child fall asleep? R ROCKING EATING PACIFIER FUSS A LITTLE?

In what position does he/she sleep best? BACK OR SIDE?

What does child sleep with? _____

DIAPERING/TOILETING

Does your child have a tendency to get diaper rash? YES NO

If yes, what do you do to alleviate it? _____

What words are used at home in reference to toileting?

What are your goals/desires regarding toilet training?

Parent's Signature: _____ Date: _____

Director's Signature: _____ Date: _____

PART B FOR CHILDREN OVER 2 YEARS ON SECOND PAGE

**FORM REQUIRED
FOR ALL CHILDREN**

Childs Name: _____ Child's Age: _____ Today's Date: _____

PART B: FOR CHILDREN OVER 30 MONTHS OF AGE

Circle one: My child is a: good moderate picky eater.

Are there any special dietary needs? Please Explain:

Has your child had any regular caregivers outside the immediate family, or any prior group experience? If yes, describe.

Please note any distinguishing physical and/or emotional characteristics which you feel may affect your child's total behavior (e.g. high activity level, sensitive, large for age, tires easily, etc.....).

Does your child have any fears that we should be aware of? How do you deal with these fears?

Has your child had any serious accidents, serious illnesses, operations, hospitalizations, disabilities, or convulsions? Describe those or any other pertinent medical facts.

Any major domestic type of events that may have affected your child?

How does your child relate to strangers?

What makes your child angry or upset?

Does your child nap? YES NO How long does he/she normally nap for? _____

Does your child use a pacifier, thumb sucking or cling to a blanket? If so, please describe when it is needed.

Is any other language other than English spoken at home?

If your child has words or sounds that are not commonly used by others, please list their meaning:

Are there any areas of your child's speech/language development that concerns you? If so, has it been professionally diagnosed?

Parent's Signature: _____ Date: _____

Director's Signature: _____ Date: _____

PERIODIC UPDATES ON INFANT & CHILD'S NEEDS MAY BE REQUIRED

**FORM REQUIRED
FOR ALL CHILDREN**