



Lincoln School of Early Learning
Child Development Center

1366 N. Gould Street, Coquille, OR 97423

Lincoln Office: 541-396-2181 ext. 2214

Daycare Office: 541-396-6322

Sharon Nelson, Director

Morgan Eley, CDC Coordinator

Dear Parents,

Welcome to Lincoln School's Child Development Center. We are delighted you chose us to be a very important part of your child's learning and growing experiences. Our goal is to provide a high quality, nurturing and safe learning environment for your child. We take this role and responsibility very seriously and consider it a privilege to have this opportunity. We are committed to providing dedicated and trained qualified staff members who are devoted to the care and well-being of the children and families we serve.

We will support children's early learning and exploration through engaging, developmentally age-appropriate materials and indoor/outdoor play activities. Early literacy starts with reading books and telling favorite stories will give children a love of books even before they start reading. Pre-writing skills start with finger-painting and are enhanced by opportunities to experiment with writing activities. Children learn valuable lessons in sharing and cooperation while interacting together in the classroom and on the playground. Meals and rest times are also an integral part of the daily schedule.

As a partner in your child's development, we value your trust in us caring for your child. You are welcome to visit and/or participate in our program anytime. We look forward to your involvement as we join together in teamwork for the continued success and growth of your child.

Sincerely,

Sharon Nelson, Director



Lincoln School of Early Learning
Child Development Center

Getting your child registered with us!

- ✓ Scan through this packet first so you know what you will need to complete it.
- ✓ Complete the forms. We recommend always keeping a copy for yourself since some of the forms are required to be completed annually.
- ✓ Make sure to complete the Schedule Preference Form. You must call before dropping your child off on a non-scheduled day/time. We cannot guarantee drop in service will be available on a day you are not scheduled to attend due a capacity issue on that particular day.
- ✓ Mail or drop off your completed packet to:
 - * Morgan Eley, CDC Coordinator
 - * Lincoln School of Early Learning - CDC
 - * 1366 N. Gould St.
 - * Coquille, OR 97423
 - * CDC office phone: 541-396-6322
- ✓ Wait for a telephone call from the CDC coordinator. We will review your packet to make sure it is complete and call you for an intake appointment. Intake appointments will take approximately 30 minutes and please bring your child with you!
- ✓ Please note that our rosters fluctuate with the academic year. Our goal is to serve every family who needs care for their children. It may take up to several weeks before we are-able to place you on our roster. We will call you with an update within a week after receiving your packet.



Coquille School District #8

Building individual success for all children

Welcome to Lincoln School of Early Learning Child Development Center

"With our community partners, providing an educational environment that promotes and builds individual success for all children."

Thank you for your interest in Lincoln School's Child Development Center. The accounting office is dedicated to providing you with great customer service. For any questions having to do with your account status, please do not hesitate to contact us at 541-396-2181.

For questions, please contact Lincoln School office at 541-396-2811. Ext. 2214 or Coordinator Morgan Eley in the Child Development Center at 541-396-6322. All registration packets should be submitted to Lincoln.

Hours of Operation

Child care services are provided from **7:00 AM to 5:30 PM, Monday through Friday**. If you cannot be here by 5:30, please make arrangements for your child to be picked up. **PLEASE DO NOT BE LATE.**

Holidays

We are closed for 10 holidays during the year:

New Year's Day

MLK Jr. Day

President's Day

Memorial Day

4th of July

Labor Day

Veteran's Day

Christmas Day

Thanksgiving Day

Day after Thanksgiving

Please also note that the day before Thanksgiving, Christmas and New Year's Eve, the daycare will close at 2 PM.

Registration

Children ages 30 months through 9 years old are eligible for child care. When a child turns 10 they will age out of our program. Children 10 and over will need to be cared for by someone other than at the child care facility.

An Intake meeting and ALL registration forms must be completed prior to your child's first day of attendance. Children are admitted without regard to race, culture, sex, religion, national origin or disability based on space availability

Monthly Fees

- Hourly rate of \$3.60 per hour (billed on ½ hour increments)
- 10% discount additional siblings (ask for details)
- DHS qualified, provider # BN000015. Please note that failure to sign your paperwork each month will result in your responsibility for the entire payment.

Payment/Late Fee Charges

Time sheets will be processed after the last day of the month. Payment is due upon receipt and subject to late fees of \$10.00 EACH DAY after the 10th of the month.

If your account has not been paid in full within 5 business days, your child may be suspended or discharged from the program.

Returned Checks/Rejected Transaction Charges

All returned checks or rejected credit card transactions will be charged a fee of \$25.00. This charge may be collected electronically. A returned check or rejected transactions will result in your account being placed on a "cash only" status.

I/We the undersigned have read and agree with the above statements. The child or children that I would like to enroll in Lincoln School of Early Learning's Child Development Center is/are:

_____	_____
Name (Please print)	Age
_____	_____
Name (Please print)	Age
_____	_____
Name (Please print)	Age
_____	_____
Name (Please print)	Age

Please be sure to sign this form.

The section below / on next page is for use by the accounting office.

I am paying by _____ Cash _____ Check _____ Credit Card

_____ DHS Eligible _____ Letter Attached

Parent/Guardian

Date

Print Name

Parent/Guardian

Date

Print Name



Lincoln School of Early Learning
Child Development Center

Schedule Preference Form

Date: _____

Name of Child: _____

Date of Birth: _____

Please check which session(s) you would like your child to attend below, and CIRCLE the days you will be attending.

Before school: 7:00 - 7:50 am

M T W Th F

After school: 2:15 - 5:45 pm

M T W Th F

During School (Pre-school) 8:00 am — 2:15 pm

M T W Th F



Lincoln School of Early Learning
Child Development Center

Getting to know you!

Child's Name: _____ DOB: _____

1. What name will your child use during the day if different than above?
2. Has your child ever attended a preschool or daycare setting?
3. Does your child have any allergies? If so, what do we need to be aware of?
4. How does your child look or what does he/she sound like when they are about to get tired, angry, or sick?
5. How is your child best comforted when upset or sad?
6. What is your child's favorite song? Favorite book?
7. What is your child's preferred napping schedule or routine? Do they have a blanket, stuffed animal? Do they need help falling asleep with quiet lullaby music, white noise, rocking?
8. Tell us about your family's celebrations.
9. Is your child potty trained? If not, what approaches are you using to train your child?

10. Tell us something special about your child. What do they like? Do they have special skills (social, art, sports, music, reading, puzzles, math games, etc)?

11. May we take and use your child's photo for classroom use only? It will be used only for our educational purposes in the class setting. A picture with you and your child? Again, this is for classroom / educational use only.

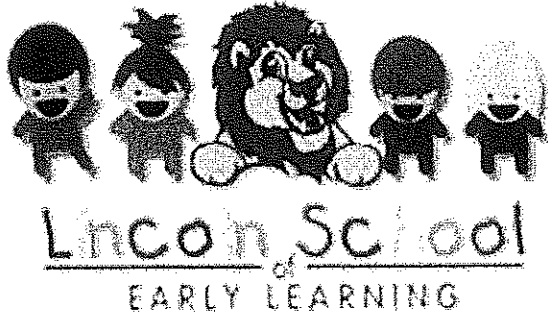
12. Are there any special experiences, events, or concerns in your child's life that you want to share (births, deaths, change of residence, etc.)?

13. Who will usually be the person dropping off and picking up your child? Who might be the other person who will occasionally do it?

14. What is the best way to reach you?

15. Do you have any questions for us?

If your child is potty training, please provide the diapers/pull-ups your child wears in their backpack. We do not supply diapers/pull-ups, so send several; we do not share with others. We also recommend that you send in your child's backpack 2 changes of clothes marked with their names. Accidents and mishaps do happen!



To: Parents

Sunscreen Applied Permission Form

I _____, give Lincoln's Child Development Center permission to administer and apply sunscreen for my child _____ during the program hours.

** Please bring in your own bottle of sunscreen. Label your child's name on the bottle and give it to the caregivers for safe keeping.**

Parent/Guardian's Signature

Date _____

NOTE: Please return this form to Lincoln's Child Development Center when completed.

Lincoln School of Early Learning REGISTRATION FORM

STUDENT INFORMATION: (Please print) Grade: _____ DOB: _____ Homeroom _____

Name: _____ Gender _____
Last First Middle

Legal Name: _____ Language Spoken in Home: _____
(If different than above)

Ethnic Group _____
(Hispanic, Caucasian, Black, Asian, Native American)

HOUSEHOLD PARENT/GUARDIAN INFORMATION (Lives With)

1st Parent

Name: _____ Primary Phone: _____ Other Phone: _____
(Guardian - Contact)

Email Address: _____

Employer: _____ Work Number: _____

Circle Relationship: Mother Father Guardian Step-Parent Grandparent Other: _____

Mailing Address: _____ City, State & Zip: _____

Physical Address: _____ City, State & Zip: _____
(If different from mailing address)

2nd Parent

Name: _____ Primary Phone: _____ Other Phone: _____
(Guardian - Contact)

Email Address: _____

Employer: _____ Work Number: _____

Circle Relationship: Mother Father Guardian Step-Parent Grandparent Other: _____

Address: _____ ONLY IF DIFFERENT THAN ABOVE

NON-RESIDENT PARENT INFORMATION

1 - Name: _____ Primary Phone: _____ Other Phone: _____
(Parent/Guardian)

Circle Relationship: Mother Father Guardian Step-Parent Other: _____

Email Address: _____

Mailing Address: _____

City _____ State _____ Zip: _____

2 - Name: _____ Primary Phone: _____ Other Phone: _____
(Parent/Guardian)

Circle Relationship: Mother Father Guardian Step-Parent Other: _____

OVER - Please sign and date the back of this form.

EMERGENCY CONTACTS: Please list in the order to be contacted in an emergency. These Contacts will also be able to pick up and drop off your student.

_____	_____	_____	_____
Name	Relationship	Primary Phone	Other Phone
_____	_____	_____	_____
Name	Relationship	Primary Phone	Other Phone
_____	_____	_____	_____
Name	Relationship	Primary Phone	Other Phone

Military Connected Student –Is a parent or guardian *currently* an active member of the Armed Forces or National Guard? **YES or NO**

Educational Background

Has your student been identified for Special Education/IEP?	Yes	No
Has your student attended Pre-K program? Where? _____	Yes	No
Has your student been identified for a 504 Plan?	Yes	No
Has your student been Homeschooled?	Yes	No
Has your student been identified for Talented and Gifted (TAG)?	Yes	No
Does your child take medication at school _____ at home _____	Yes	No
Does your child have a severe food allergy	Yes	No
My child has been seeing a counselor	Yes	No
My child has a behavior problem	Yes	No
My child has special needs	Yes	No
My child may be released to either parent	Yes	No
Are custody papers on file for your child?	Yes	No
My child needs to wear glasses	Yes	No
My child has a hearing problem	Yes	No

Mark special services your child was receiving at previous school:
 ___ Speech ___ Special reading ___ IEP ___ 504 ___ Indian Education
 ___ English as a Second Language ___ Other _____

 Parent/Guardian Signature _____
 Date

2021/2022
HEALTH INFORMATION FORM
 Lincoln School of Early Learning

STUDENT: _____ **DOB:** _____ **Gr/Teacher:** _____
 Parent(s): _____ Phone: (home) _____ (work) _____
 Emergency Contact other than parent: _____ Phone: _____
 Physician's Name and Phone Number: _____

This information may be shared with appropriate school staff or health care provider

Please check (✓) any conditions, disorders, or history of other health problems that apply:

___ **ASTHMA:** _____ **Mild** _____ **Persistent** _____ **Severe**
 Will student need to have a rescue inhaler at school? _____ **Yes** _____ **No**
 Asthma Triggers: _____

___ **ALLERGIES:** _____ **SEVERE:** _____ **Bee Sting** _____ **Peanuts** _____ **Other:** _____

Describe symptoms: _____
 Is an Epi-Pen prescribed? _____ **Yes** _____ **No**

___ **FOOD ALLERGIES:** What food(s)/symptoms? _____
An order from your health care provider is required for a food/drink substitution

___ **MEDICATION ALLERGIES:** _____
 ___ **OTHER ALLERGIES:** _____

___ **DIABETES:** ***A health care management plan must be in place before student attends school***

___ **SEIZURE DISORDER**

- | | | |
|--------------------------------|--|---------------------------------------|
| ___ Abdominal / Stomach | ___ Concussions / Head injuries | ___ Vision, Eye Problems/ Color Blind |
| ___ ADD / ADHD | ___ Emotional / Mental Health Issues | ___ Other _____ |
| ___ Auditory/ Hearing problems | ___ Headaches / Migraines | _____ |
| ___ Autism | ___ Immune Disorder | _____ |
| ___ Bladder / Kidney Problems | ___ Muscle / Bone / Joint disease / injury | _____ |
| ___ Bleeding Disorder | ___ Neurological Disorder | _____ |
| ___ Bowel Problems | ___ Skin Disorder | ___ NONE OF THE ABOVE |
| ___ Cardiac / Heart Problems | ___ Thyroid Problems | |

Describe any concern noted above: _____

MEDICATIONS taken regularly at home/school: _____

An MD order and/or written instructions from parent are required for administration of medication at school

PERMISSION FOR VISION, SPEECH, DENTAL AND HEARING SCREENING

___ **Yes** ___ **No** I give permission for my child to participate in the school's annual vision, speech, dental and hearing screenings.

PERMISSION FOR EMERGENCY TREATMENT

If I cannot be located, in case of an emergency, school officials are authorized to call an ambulance and/or transport my child to a medical facility to be treated by the doctor on duty. The doctor on duty is authorized to give consent for any procedure of hospital care deemed advisable.

Parent Signature: _____ **Date:** _____

Coquille School District
Student Race and Ethnicity Reporting

Student Name: _____ Date Form Completed: _____

Date of Birth: _____ Male Female

Person Completing This Form: Parent/Guardian Student Other: _____

The U.S. Department of Education has implemented new standards for school districts to report student race and ethnicity. Your answers to the following will be held strictly confidential and data will be used only in the aggregate.

1. Is your child of Hispanic, Latino, or Spanish ethnicity: Yes No
Includes persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin.

If you answered "Yes" to question #1, you may also check one or more of the racial categories in question #2. If you answered "No", please check one or more of the following racial categories.

2. Racial Categories:

- American Indian or Alaska Native
Origins in any of the original peoples of North, Central, and South America who maintain a tribal affiliation or community attachment.
- Asian
Origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent for example Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, Philippine Islands, Thailand, and Vietnam.
- Black or African American
Origins in any of the black racial groups of Africa
- Native Hawaiian or Other Pacific Islander
Origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- White
Origins in any of the original peoples of Europe, the Middle East, or North Africa.

Please complete the entire form and return it to:

Name: _____ Phone Number: _____

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

OFFICE USE ONLY	
<small>Race/Ethnicity Code</small>	

Coquille School District

Informe sobre la raza y origen étnico de los estudiantes

Nombre del estudiante: _____ Fecha en que se llenó el formulario: _____

Fecha de nacimiento: _____ Masculino Femenino

Persona que llena este formulario: Padre de familia/tutor legal Estudiante Otro: _____

La Secretaría de Educación de Estados Unidos ha implementado nuevos estándares para que los distritos escolares informen sobre la raza y origen étnico de los estudiantes. Sus respuestas a lo siguiente se mantendrán estrictamente confidenciales y los datos se utilizarán únicamente en conjunto.

1. Es su hijo de origen étnico hispano, latino o español: Sí No
 Incluye personas de origen cubano, mexicano, puertorriqueño, sudamericano o centroamericano u otra cultura española.

Si respondió "Sí" a la pregunta 1, también puede marcar una o más de las categorías raciales de la pregunta 2. Si respondió "No", marque una o más de las siguientes categorías raciales.

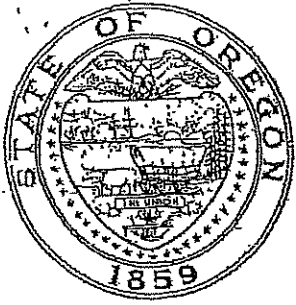
2. Categorías raciales:
- Indio americano o Nativo de Alaska
Se origina de cualquiera de los grupos originales de personas de Norte, Centro y Sudamérica quienes mantienen una afiliación con esas tribus o conexión con la comunidad.
 - Asiático
Se origina en cualquiera de los grupos originales de personas del Lejano Oriente, Sudeste asiático o el subcontinente indio, por ejemplo, Camboya, China, India, Japón, Corea, Malasia, Pakistán, Filipinas, Tailandia y Vietnam.
 - Negro o afro americano
Se origina en cualquiera de los grupos raciales negros de África
 - Nativo de Hawai u otra isla del Pacífico
Se origina en cualquiera de los grupos originales de personas de Hawai, Guam, Samoa u otras islas del Pacífico.
 - Blanco
Se origina en cualquiera de los grupos originales de personas de Europa, Oriente Medio o Norte de África.

Por favor llene el formulario completo y devuélvalo a:

Nombre: _____ Número de teléfono: _____

Dirección: _____ Ciudad: _____ Estado: _____ Código postal: _____

OFFICE USE ONLY	
Race/Ethnicity Code:	



Oregon Certificate of Immunization Status Oregon Health Authority, Immunization Program

Oregon law requires proof of immunization be provided or an exemption be signed prior to a child's attendance at school, preschool, child care or home day care. This information is being collected on behalf of the Oregon Health Authority, Immunization Program and may be released to the Authority or the local public health department by the school or children's facility upon request of the Authority. Please list immunizations in the order they were received.

Child's Last Name <i>Apellido</i>	First <i>Primer Nombre</i>	Middle Initial <i>Segundo Nombre</i>	Birthdate <i>Fecha de Nacimiento</i>	Complete for all
Mailing Address <i>Dirección</i>	City <i>Ciudad</i>	State <i>Estado</i>	Zip Code <i>Código Postal</i>	
Parents' or Guardians' Names <i>Nombre de los padres o guardian</i>			Home Telephone Number <i>Número de Teléfono</i>	Medical
Non medical				

Vaccines	Dose 1 <small>(mm/dd/yy)</small>	Dose 2 <small>(mm/dd/yy)</small>	Dose 3 <small>(mm/dd/yy)</small>	Dose 4 <small>(mm/dd/yy)</small>	Dose 5 <small>(mm/dd/yy)</small>
Diphtheria/Tetanus/Pertussis (DTaP, Tdap, Td)					
Booster Dose Tdap					
Polio (IPV or OPV)					
Varicella (Chickenpox) [VZV or VAR] <input type="checkbox"/> Check here if child has had chickenpox disease _____ <small>(mm/dd/yy)</small>					
Measles/Mumps/Rubella (MMR) <i>or</i> Measles vaccine only Mumps vaccine only Rubella vaccine only					
Hepatitis B (Hep B)					
Hepatitis A (Hep A)					
Haemophilus Influenzae Type B (Hib) (Only children less than 5 years)					

I certify that the above information is an accurate record of this child's immunization history.

Signature* _____	Date _____
Update Signature _____	Date _____
Update Signature _____	Date _____
Update Signature _____	Date _____

For school/facility use only
School/facility Name
Student ID Number
Grade

*Parent, guardian, student at least 15 years of age, medical provider or county health department staff person may sign to verify vaccinations received.

Continued On Reverse Side



Oregon Certificate of Immunization Status, Page 2
Oregon Health Authority, Immunization Program

Child's Last Name <i>Apellido</i>	First <i>Primer Nombre</i>	Middle Initial <i>Segundo Nombre</i>	Birthdate <i>Fecha de Nacimiento</i>
---	--------------------------------------	--	--

	Recommended Vaccines	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Recommended Vaccines	Pneumococcal (PCV) (Only in children less than 5 years)					
	Meningococcal (MCV4, MPSV4)					
	Human Papilloma Virus (HPV) (9 years or older)					
	Influenza (Flu)					
	Other Vaccine Please specify:					
	Other Vaccine Please specify:					

For medical exemptions:
 Please submit a letter signed by a licensed physician stating:

- * Child's name
- * Birth date
- * Medical condition that contraindicates vaccine
- * List of vaccines contraindicated
- * Approximate time until condition resolves, if applicable
- * Physician's signature and date
- * Physician's contact information, including phone number

For Immunity Documentation (history of disease or positive titer): Please submit a letter signed by a licensed physician stating:

- * Child's name and birth date
- * Diagnosis or lab report
- * Physician's signature and date

Nonmedical Exemption:
 I have received information regarding the benefits and risks of immunizations. I understand that my child may be excluded from school or child care attendance if there is a case of disease that could be prevented by vaccine. I have attached the required document from (check one):

A health care practitioner
 The vaccine educational module approved by the Oregon Health Authority

I understand that I may decline one or more vaccinations for my child and request that my child be exempted from the following required immunizations (check all that apply):

<input type="checkbox"/> Diphtheria/Tetanus/Pertussis	<input type="checkbox"/> Hepatitis B
<input type="checkbox"/> Polio	<input type="checkbox"/> Hepatitis A
<input type="checkbox"/> Varicella	<input type="checkbox"/> Hib
<input type="checkbox"/> Measles/Mumps/Rubella	

Signature of Parent or Guardian _____ Date _____

Optional:
 ORS 433.267 states that this document may include the reason for declining the immunization. Immunization is being declined because of:

Religious belief Philosophical belief Other

I certify that the above information is an accurate record of this child's immunization history and exemption status.

Signature _____ Date _____

Update Signature _____ Date _____

Update Signature _____ Date _____

Update Signature _____ Date _____

How to claim a new nonmedical exemption to school/children's facility immunization requirements in Oregon, starting March 1, 2014

1. Complete the required education from a health care practitioner or online vaccine education module at www.healthoregon.org/vaccineexemption.
2. Get a Vaccine Education Certificate from the health care practitioner or print a certificate from the online vaccine education module. Turn the completed Vaccine Education Certificate into your child's school or childcare with a completed Certificate of Immunization Status form.
3. Get a Certificate of Immunization Status from your child's school or childcare, or at www.1.usa.gov/OregonSchool. Fill out the nonmedical exemption portion of the Certificate of Immunization Status, marking the vaccines for which you would like a nonmedical exemption for your child. Turn the completed Certificate of Immunization Status into your child's school or childcare with the completed Vaccine Education Certificate.

Helpful hints for claiming a nonmedical exemption:

- Some health care practitioners may not provide the Vaccine Education Certificate. Check with your health care practitioner first.
- If you have multiple children for whom you'd like a nonmedical exemption, you need a Vaccine Education Certificate for each child.
- Keep a copy of the Vaccine Education Certificate for your own records.
- The date on the Vaccine Education Certificate and Certificate of Immunization Status must be within 12 months of the date you enroll your child in school or childcare.
- Listing a vaccination history for your child does not affect your right to a nonmedical exemption. We encourage you to document any vaccinations your child has received so that their medical history is as complete as possible.

All of us have a stake in making sure that children stay healthy and avoid illness. In Oregon, all children attending school or childcare are required to have certain immunizations or an appropriate medical or nonmedical exemption.

Some people cannot be vaccinated because of medical conditions—and exposure to a vaccine-preventable disease could be fatal to them. If your child has been exposed to a disease, intentionally or not, keep them home at the first sign of illness.

Responsibilities: Actively choosing not to immunize your child is a parent's right; however, it carries with it a significant responsibility: not exposing others to communicable disease.

Rights: No one can deny a parent the right to claim a nonmedical exemption. If you were told that you cannot claim a nonmedical exemption, please report it to the Oregon Immunization Program at 971-673-0300.

