



People **Serving** People

614 S. 3rd St.
Minneapolis, MN 55415
(612) 332- 4500



810 S. 7th St.
Minneapolis, MN 55415
(612) 249 - 5337

Application for Child Care Services

Thank you for your interest in attending the Early Childhood Development Center or 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 required steps 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!

Center of Excellence:

Gail Allen, Director
Arrianne Slaughter, Assistant Director
612-249-5337
Fax: 612-335-4599

Early Childhood Development Center:

Meredith Johnson, Director
Patricia Peoples, Assistant Director
612-277-0267

Steps to Enroll

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

- You will need additional paperwork if your child has: medical needs, allergies, asthma, etc. (we will provide)

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 of the site and a meeting with your child's teacher so meet and talk about your child

For information about enrolling at ECDP: Contact Patricia: 612-277-0627 (office 201),
for the CoE: Contact Gail: 612-335-4599

Documents Needed

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)

Application for Child Care Assistance and/or Pathway Scholarship

Revised 3/15/2025

General Information

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

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

Adults Name: _____ Main Number: _____ Other: _____
☐ Cell ☐ Work ☐ Home ☐ Cell ☐ Work ☐ Home

Place of work/School: _____

Adults Name: _____ Main Number: _____ Other: _____
☐ Cell ☐ Work ☐ Home ☐ Cell ☐ Work ☐ Home

Place of work/School: _____

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 _____

Has your child experienced or witnessed any of these:

- ☐ Domestic Violence
- ☐ Emotional Abuse/Psychological Maltreatment
- ☐ Physical Maltreatment/Abuse
- ☐ Neglect
- ☐ Sexual Maltreatment/Abuse
- ☐ Serious Injury/Accident

If you checked a box, please explain about what your child experienced or witnessed so we can better support your child.



People **Serving** People

614 S. 3rd St.
Minneapolis, MN 55415
(612) 332- 4500



810 S. 7th St.
Minneapolis, MN 55415
(612) 249 - 5337

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:	
Has your child been evaluated for a developmental or learning concern? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Does your child have an Individual Education Plan and/or receiving special services? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Other:	

Has your child had Early Childhood Screening? YES ☐ NO ☐

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? _____

What are your child's strengths?

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

Activities your child enjoys:

☐ Books ☐ Music ☐ Pretend Play ☐ Physical Exercise ☐ Blocks/Legos ☐ Other _____

How does your child show anger or frustration (cries, withdraws, throws, hits, etc.)?

What are your child's fears?

How is your child best comforted?

☐ Held ☐ Given space ☐ Talked to/with ☐ Redirected ☐ 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 _____



People **Serving** People

614 S. 3rd St.
Minneapolis, MN 55415
(612) 332- 4500



810 S. 7th St.
Minneapolis, MN 55415
(612) 249 - 5337

Child's Name: _____ DOB: _____

Authorized Pickups and Emergency Contacts

In case you are unavailable to pick up your child, list other people that are authorized to pick up your child. (Anyone picking up your child will need to provide a picture ID). In the event of illness or medical emergency, list other people that can reach you and/or pick up your child if they are ill and you cannot be reached.

Name: _____ Number: _____ Relationship: _____

☐ Authorized to pick up ☐ Emergency contact ☐ Cell ☐ Work ☐ Home

Address: _____

Name: _____ Number: _____ Relationship: _____

☐ Authorized to pick up ☐ Emergency contact ☐ Cell ☐ Work ☐ Home

Address: _____

Name: _____ Number: _____ Relationship: _____

☐ Authorized to pick up ☐ Emergency contact ☐ Cell ☐ Work ☐ Home

Address: _____

Medical Provider Information

Child's Physician/Doctor: _____ Phone: _____

Address: _____ Preferred Hospital: _____

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

- ☐ I give permission to People Serving People/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 People Serving People/The Center of Excellence to find emergency care for my child. I accept responsibility for cost not covered by insurance.

Parent Signature: _____ Date: _____

Contact Information and Schedule

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:

Activity Adults are engaged in:

- ☐ School
- ☐ Work
- ☐ Other: (explain) _____

I understand that I am contracting for these hours of care. If I need to make a change to the hours of care, I will consult with the Assistant Manager or Manager of my site. I also understand that there are other circumstances that may cause there to be a change in the contract for care. These circumstances will be discussed with me by the Assistant Manager or Manager of my childcare site.

Parent Signature

Date



People **Serving** People

614 S. 3rd St.
Minneapolis, MN 55415
(612) 332- 4500



810 S. 7th St.
Minneapolis, MN 55415
(612) 249 - 5337

Permissions

Neighborhood Walks:

As an extension of our curriculum and program, children may take neighborhood walks on a regular basis. Neighborhood walks will be within a 6-block radius (1/2 mile) from the center. During neighborhood walks the children will be in strollers/buggies (infants and/or young toddlers) or walking with a walking rope (preschool). All neighborhood walks will have an adequate number of adults to provide active supervision.

- ☐ My child has permission to go on neighborhood walks within 0.6 miles of the Center

Over the counter and topical products:

- ☐ I give staff at People Serving People/The Center of Excellence permission to use the following over the counter or topical products as needed (provided by the center):
- sunscreen,
 - bug spray,
 - diaper cream/ointment,
 - diaper wipes,
- ☐ I give staff at People Serving People/The Center of Excellence permission to use the following over the counter or topical products as needed and will provide these products for my child:
- Lip balm
 - Lotion

Photos:

Pictures are sometimes taken. These pictures will only be used in the classroom or given to parents. If any other pictures are taken, we will have a separate release form for you to sign on that day.

- ☐ 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)

Educational Assessments and Family Conferences:

People Serving People/The Center of Excellence utilizes Teaching Strategies Gold as an educational assessment and the Ages & Stages Questionnaire as a growth and development checklist. The results of these assessments will be used for family conferences and tracking age-appropriate development.

- ☐ I give People Serving People/The Center of Excellence permission to give my child assessments for conferences and tracking age-appropriate development.

Center of Excellence:

- ☐ I understand that 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 of losing my spot, and if I am not able to pay this fee I will request a meeting with a director.

Signature: _____ Date: _____