



Welcome to Stepping Stones! Here are a few items to help with your child's first day. Please remember to bring in our completed enrollment packet and a copy of your child's updated immunization records.

On your first day:

- **Infants**
 - 1 Package of diapers and wipes
 - Bottles including caps labeled with child's first and last name
 - Water for bottles
 - Formula/breastmilk
 - Diaper Cream and powder when needed
 - 2 complete change of clothes
 - 1 sleep sack (optional)
 - Jars of food and cereal (if needed)
- **Toddler and Two year olds**
 - 1 package of diapers/ pull ups and wipes
 - Napper/ Nap mat (can purchase with Administration)
 - 2 complete change of clothes
 - 3 pairs of underwear if potty training
 - Diaper cream and powder when needed
 - Sweater and/or jacket to accommodate indoor/ outdoor temperature changes
 - Please label all items with child's name
- **Preschool and Pre-Kindergarten**
 - Napper/ Nap mat (can purchase with Administration)
 - 2 complete changes of clothes
 - Sweater and/or jacket to accommodate indoor/ outdoor temperature changes
 - Please label all items with child's name



Stepping Stones Child Care

Child's name (last, first, middle):	Name called:	Age:	Sex:	Birthdate:
Father's name (last, first, middle):	Please circle one: Dr. Mr.			
Address (street, city, state, zip):	Home phone (please indicate which # to call first):			
Place of Employment:	Work phone/cell phone:	Email Address:		
Mother's name (last, first, middle):	Please circle one: Dr. Mrs. Ms.			
Address (street, city, state, zip):	Home phone (please indicate which # to call first):			
Place of Employment:	Work phone/cell phone:	Email Address:		
Person(s) authorized to pick-up child other than parent (name, address, phone#):				
Person(s) to contact in emergency (should both parents be unavailable):				
Program in which child will be enrolled: Infants Pre-Toddlers Toddlers Pre-school Partial Day Private School After-school				
Time: from _____ to _____		Numbers of days each week: M T W Th F		
Beginning Date:				
Private Physician:	Address:	Phone:		
Hospital:				
Public/Private School Attending: _____ Address: _____ Phone: _____				
<input type="checkbox"/> His/Her immunization record is on file at the school and all required immunizations and/or Tuberculosis test are current. Vision and Hearing screening records are also on file.				

Authorizations:

I hereby authorize Stepping Stones to share all health information regarding my child with all relevant Stepping Stones employees, and I authorize Stepping Stones to share my contact information for classroom directories.

Parent/Guardian Signature

Date

I hereby authorize Stepping Stones personnel to take my child to the above named physician or facility for medical treatment in the event of an emergency in which neither parent can be reached.

Parent/Guardian Signature

Date

I hereby authorize any licensed physician or medical treatment center to treat my child in case of an emergency in which the above named physician cannot respond.

Parent/Guardian Signature

Date

I hereby authorize Stepping Stones personnel to transport my child to or from school, on educational excursions, or on other center sponsored activities under proper supervision and adequate transportation (bus or otherwise).

Parent/Guardian Signature

Date

I hereby authorize Stepping Stones to allow my child to participate in water activities.

Parent/Guardian Signature

Date

A child who appears ill upon arrival shall not be admitted into the facility. When a child becomes ill at the center, the parent will be contacted and arrangements made for the child to be picked up within the hour. At the time of registration, the parents should authorize the child's physician to accept all calls from the center's directors for emergency medical care.

Parent/Guardian Signature

Date

I hereby authorize Stepping Stones to apply sunscreen and bug repellent to my child when venturing outdoors.

Parent/Guardian Signature

Date

I hereby authorize Stepping Stones to permit photographs of my child for portfolio assessment, artwork, and publication purposes. I will not seek compensation for photos.

Parent/Guardian Signature

Date

I hereby authorize Stepping Stones to post any necessary allergy information in my child's classroom.

Parent/Guardian Signature

Date

I acknowledge that I have read the Stepping Stones parent handbook.

Parent/Guardian Signature

Date

WAIVER AND RELEASE OF LIABILITY

SECTION I

Field Trips, Swimming, Extracurricular Activities & On School Grounds

It is the intention of both (names of parents) _____, _____ and Stepping Stones Child Care, its owners, officers, directors, agents and employees shall not be liable or in any way responsible for damage, loss or expense resulting to (names of children) _____ due to accidents, mishaps, or injuries, either to person or property, or of any nature or property, of any kind arising from any cause whatsoever *except such damage, loss, or expense arising from intentional misconduct of Stepping Stones Child Care, its owners, officers, directors, agents and employees acting within the scope of their employment.*

I/We (names of parents) _____, _____ further grant permission for my child to participate in any event sponsored by Stepping Stones Child Care. I fully recognize and understand the dangers of such activity and agree to assume full responsibility and hereby release the Stepping Stones Child Care, its owners, officers, directors, agents and employees from any and all liabilities, claims, suits, demands, or causes of action which arise from my child's participation, *except such damage, loss, or expense arising from intentional misconduct of Stepping Stones Child Care, its owners, officers, directors, agents and employees acting within the scope of their employment.*

SECTION II

Severability

It is further understood and agreed by the parties to this instrument that if any provisions of this agreement should contravene or be invalid under the law of Texas or the United States, such contravention or invalidity shall not invalidate this agreement, but agreement shall be construed as if not containing the particular provision or provisions held to be invalid, and the rights and obligations of the parties to this agreement shall be construed and enforced accordingly. In witness whereof, the parties have executed this agreement at the day and year first above written.

Signature of Parent or Legal Guardian

Date

Signature of Stepping Stones Representative

Date

Notary Public, State of Texas

**Stepping Stones Child Care
10601 Falconwing Drive
The Woodlands, TX 77381
281-298-5838**

ALLERGY NOTIFICATION FORM

Child's Full Name: _____

What allergies does your child have: (if none, please write none)

What is the reaction?

Do we have your permission to post your child's allergies in each room where your child spends time? Yes / No

What emergency plan would you like us to have in place for your child?

Parent Signature

Date

**Please attach a
photo here if
there are allergies**

**Health Care Professional's Signature
(Needed only if an Emergency Plan is in Place)**

Date



PARENT HANDBOOK ACKNOWLEDGEMENT

- ___ 1. The registration fee is \$100 per child or \$200 for multiple children and is annual and non-refundable. Stepping Stones also charges a \$50 supply fee per child upon enrollment.
- ___ 2. You are required to give us 30 days written notice prior to withdrawing your child. In addition, should it become necessary to change your child's program days, a 2-week written notice is required.
- ___ 3. The monthly tuition for the _____ program you have selected is currently \$_____ and Stepping Stones reserves the right to charge families an increase annually.
- ___ 4. Tuition is due on the first day of each month. A \$5.00 late charge may be added each day thereafter.
- ___ 5. In addition to your tuition, there may be a charge for any extra-curricular activities you choose for your child (i.e. Fun Pack).
- ___ 6. You may make payments by cash, check, Visa, or Master Card.
- ___ 7. We are open from 6:00 AM to 6:30 PM Monday through Friday. We are closed on following holidays: Labor Day, Thanksgiving and the day after, Christmas Eve Day, Christmas Day, New Year's Day, Good Friday, Memorial Day, and Independence Day. We do not prorate tuition for these closings.
- ___ 8. Because our program requires us to engage staff based upon the number of children enrolled, we cannot give tuition refunds for days your child is absent.
- ___ 9. All information regarding child's parent information must be included on enrollment form or court documentation must be provided.
- ___ 10. Late pick-up fees are an automatic \$15 from 6:30 PM to 6:45 PM and one dollar per minute thereafter. These fees are due in cash upon pick-up of the child.

I acknowledge that I have read the parent handbook. I am fully aware of the educational philosophy, discipline policy, and procedures for arranging conferences with the staff at Stepping Stones.

I have read and understand the fee arrangements and conditions detailed in the parent handbook. I agree to these conditions and will abide by them.

This acknowledgement must be placed in our files. Please sign form and return it to Stepping Stones.

Child's Name

Parent's Signature

Date



Stepping Stones
Child Care

Certificate of Health

This child is medically up to date not up to date on immunizations. If not up to date, immunization(s) can be made up in _____ months. The above named child has my permission to attend school.

I have examined this child and believe him/her to physically fit to participate in the normal activities in which children are involved, including outdoor play in suitable weather.

Are there any restrictions on normal physical activities indicated? Yes No

If yes, please specify: _____

Does the child have any chronic medical conditions necessitating dietary supplements or restrictions, medications, or avoidance, of allergens? Yes No

If yes, please specify: _____

Does the child have any known allergies/asthmatic problems? Yes No

If yes, special attention required: _____

Physician's Signature/Parent's Signature

Date

FOOD PROGRAM ENROLLMENT FORM

Facility Name _____

Please COMPLETE the following 7 items: (ALL 7 MUST BE COMPLETED)
Complete por favor los siguientes 7 articulos

(1) FULL NAME OF CHILD / Nombre completo del niño:

PLEASE INCLUDE ANY NICKNAMES OR ALT. LAST NAMES _____

(2) CHILD'S DATE OF BIRTH / Fecha de nacimiento: _____

(3) TIMES IN CARE / Las horas en cuidado: _____ TO _____ Example 6am to 5:30pm

(4) DAYS IN CARE / Los días en cuidado: _____ Example: Mon-Fri

(5) MEALS NORMALLY SERVED TO CHILD WHILE IN CARE/

Las comidas servidas normalmente al niño mientras en el cuidado del daycare:

BREAKFAST AM SNACK LUNCH PM SNACK SUPPER EVENING SNACK
(Please circle meals)

(6) _____ (7) _____
Signature-Parent or Adult Household member Today's enrollment date into Food Program
Firma de un miembro adulto de la unidad familiar Fecha

(8) WITHDRAWAL DATE: _____

Non-Discriminatory Policy:

In accordance with federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability.

To file a complaint of discrimination, write USDA, Office of Adjudication and Compliance, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call 202-260-1026, 866-632-9992 (toll free) or 202-401-0216 (TDD), USDA is an equal opportunity provider and employer.



CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 1. All Household Members

Name of Enrolled Child(ren):	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.	CHECK IF NO INCOME
Names of all household members (First, Middle Initial, Last)		
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

Part 2. Benefits: If any member of your household receives SNAP, TANF, or FDPIR, provide the name and case number for the person who receives benefits. If no one receives these benefits, skip to part 4.
 NAME: _____ CASE NUMBER: _____

Part 3. (Applies only to parents/guardians with children enrolled in a day care home) If any member of your household receives benefits listed on the enclosed *List of Eligible Federal/State Funded Programs (H1660)*, provide the name of the program and case number: NAME: _____ CASE NUMBER: _____
 Check here if no case number If no one receives these benefits, skip to part 4.

Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List only household members with income) <i>(Example)</i> Jane Smith	B. Gross income and how often it was received			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
	\$200/weekly	\$150/twice a month	\$100/monthly	\$200/bi-monthly
	\$ ___/___	\$ ___/___	\$ ___/___	\$ ___/___
	\$ ___/___	\$ ___/___	\$ ___/___	\$ ___/___
	\$ ___/___	\$ ___/___	\$ ___/___	\$ ___/___
	\$ ___/___	\$ ___/___	\$ ___/___	\$ ___/___

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)
 An adult household member must sign and date this form. If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the next page.)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____
 Date: _____
 Address: _____ Phone Number: _____
 City: _____ State: _____ Zip Code: _____

Last four digits of Social Security Number: * * * - * * - _____ I do not have a Social Security Number



CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:

- Hispanic or Latino
- Not Hispanic or Latino

Mark one or more racial identities:

- Asian
- White
- Black or African American
- American Indian or Alaska Native
- Native Hawaiian or Other Pacific Islander

Part 7. Sharing Information With Other Programs: OPTIONAL

The above information may be disclosed for the purpose of enrolling children in the Children's Health Insurance Program (CHIP). Parents/guardians are not required to consent to such disclosure and electing not to allow disclosure will not adversely affect a child's eligibility.

- I do elect to allow my household information to be disclosed.
- I do not elect to allow my household information to be disclosed.

Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: Week, Every 2 Weeks, Twice A Month, Month, Year Household size: _____
 Categorical Eligibility: _____ Date Withdrawn: _____ Eligibility: Free ___ Reduced ___ Denied ___ Tier I ___ Tier II ___
 Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date: _____

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. "In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."



OPERATIONAL POLICY ON INFANT SAFE SLEEP

Purpose: This form provides the required information per minimum standards §746.501(9) and §747.501(6) for the safe sleep policy.

Directions: Parents will review this policy upon enrolling their infant at

and a copy of the policy is provided in the parent handbook. Parents can review information on safe sleep and reducing the risk of Sudden Infant Death Syndrome/Sudden Unexpected Infant Death Syndrome (SIDS/SUIDS) at: <http://www.healthychildren.org/English/ages-stages/baby/sleep/Pages/A-Parents-Guide-to-Safe-Sleep.aspx>

SAFE SLEEP POLICY

All staff, substitute staff, and volunteers at

will follow these safe sleep recommendations of the American Academy of Pediatrics (AAP) and the Consumer Product Safety Commission (CPSC) for infants to reduce the risk of Sudden Infant Death Syndrome/Sudden Unexpected Infant Death Syndrome (SIDS/SUIDS):

- Always put infants to sleep on their backs unless you provide an Infant Sleep Exception form 2710 signed by the infant's health care professional [§746.2427 and §747.2327].
- Place infants on a firm mattress, with a tight fitting sheet, in a crib that meets the CPSC federal requirements for full size cribs and for non-full size cribs [§746.2409 and §747.2309].
- For infants who are younger than 12 months of age, cribs should be bare except for a tight fitting sheet and a mattress cover or protector. Items that should not be placed in a crib include: soft or loose bedding, such as blankets, quilts, or comforters; pillows; stuffed toys/animals; soft objects; bumper pads; liners; or sleep positioning devices [§746.2415 and §747.2315]. Also, infants must not have their heads, faces, or cribs covered at any time by items such as blankets, linens, or clothing [§746.2429 and §747.2329].
- Do not use sleep positioning devices, such as wedges or infant positioners. The AAP has found no evidence that these devices are safe. Their use may increase the risk of suffocation [§746.2415 and §747.2315].
- Ensure that sleeping areas are ventilated and at a temperature that is comfortable for a lightly clothed adult [§746.3407(10) and §747.3203(10)].
- If an infant needs extra warmth, use sleep clothing

(insert type of sleep clothing that will be used, such as sleepers or footed pajamas) as an alternative to blankets [§746.2415 and §747.2315].

- Place only one infant in a crib to sleep [§746.2405 and §747.2305].
- Infants may use a pacifier during sleep. But the pacifier must *not be attached* to a stuffed animal or the infant's clothing by a string, cord, or other attaching mechanism that might be a suffocation or strangulation risk [§746.2415 and §747.2315].
- If the infant falls asleep in a restrictive device other than a crib (such as a bouncy chair or swing, or arrives to care asleep in a car seat), move the infant to a crib immediately, unless you provide an Infant Sleep Exception form 2710 signed by the infant's health care professional [§746.2426 and §747.2326].
- Our child care program is smoke-free. Smoking is not allowed in Texas child care operations (this includes e-cigarettes and any type of vaporizers) [§746.3703(d) and §747.3503(d)].
- Actively observe sleeping infants by sight and sound [§746.2403 and §747.2303].
- If an infant is able to roll back and forth from front to back, place the infant on the infant's back for sleep and allow the infant to assume a preferred sleep position [§746.2427 and §747.2327].
- Awake infants will have supervised "tummy time" several times daily. This will help them strengthen their muscles and develop normally [§746.2427 and §747.2327].
- Do not swaddle an infant for sleep or rest unless you provide an Infant Sleep Exception form 2710 signed by the infant's health care professional [§746.2428 and §747.2328].

PRIVACY STATEMENT

DFPS values your privacy. For more information, read our privacy policy at:
<http://www.dfps.state.tx.us/policies/privacy.asp>.

SIGNATURES

This policy is effective on: _____ (date)

Child's name:

Signed by:

X

Director/Owner

Date signed:

Signed by:

X

Staff member

Date signed:

Signed by:

X

Parent

Date signed:



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ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) to initiate credit card charges to the below-referenced credit card account (Section A) OR, initiate debit entries to my (our) checking or savings account, indicated below (Section B). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Form fields for Section A: Cardholder Name, Phone #, Cardholder Address, City, State, Zip, Account Number, Expiration Date, Cardholder Signature, Date.

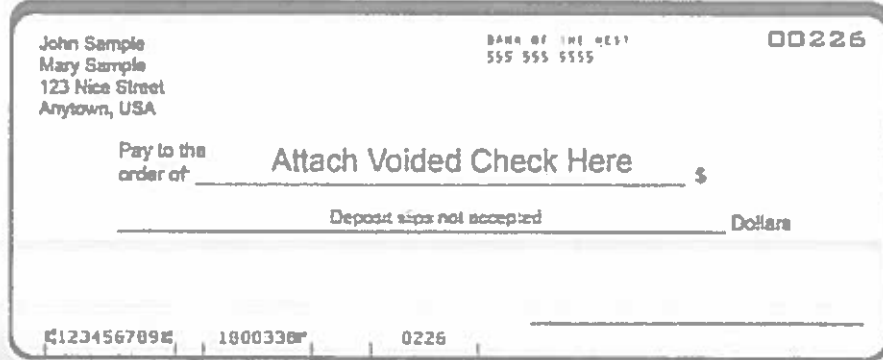
SECTION B (Bank Account)

Form fields for Section B: Your Name, Phone #, Address, City, State, Zip, Bank or Credit Union Name, Bank or Credit Union Address, City, State, Zip, Routing Transit Number, Account Number, Checking/Savings checkboxes.

Authorized Signature and Date fields.

For Official Use Only

Form fields for official use: Date Received, Employee Signature.





Want a window into your child's day?
A real-time feed of their school activities?
Photos and videos delivered straight to your mobile phone?

Meet brightwheel, an easy-to-use mobile app that helps schools and teachers stay better connected with families.

What is brightwheel?

Teachers use brightwheel for recording and tracking daily events and activities in the classroom and managing administrative tasks. As a parent, you'll get private, real-time updates on your child delivered to your mobile device throughout the day.

Daily Updates. A real-time feed of activities throughout the day.

Photos and Videos. Watch your child's day unfold with snapshots delivered right to your mobile device.

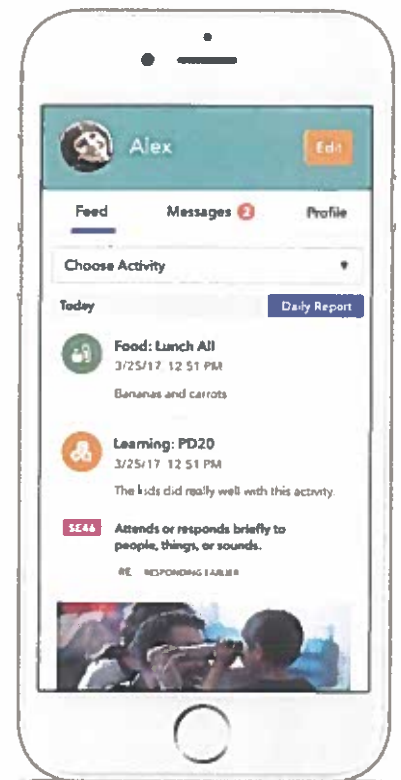
Stay Connected. Stay in touch with your teacher and strengthen learning with activities at home. Get notifications for photos, videos, notes, and check-ins.

Digital Check-in. Easy digital sign-in with your personal check-in code, digital signature, or your own device by scanning an image at your location!

Messaging. Leave notes for your teacher when your child is sick or running late.

Calendar. Quickly view upcoming events and important dates at your child's school.

Paperless Billing. Secure, online system for receiving invoices and receipts for tuition, as well as paying bills digitally. (No more checks!)



Why use brightwheel?

Parents report that the peace of mind brightwheel delivers is invaluable! We know it's tough being away from your little one all day, especially in these early years. With brightwheel you'll feel connected and engaged with your child's development on a whole new level.

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