USTC's Child Care Enrollment Form

650 Branch Avenue, Providence RI 02904
401-331-7900

Child's Name: _____ Male: ____ Female: ____
Age: _____ Birth Date: _____
Address: (Street and Number): _____
City: _____ State: _____ Zip: _____
School: _____ Grade: ___ Teacher's Name: _____

Previous Childcare Program: Yes: ____ No: ____
Name of Program: _____ Last Attended: _____

Mother/Guardian: _____ Address: _____
City:_____State:___Zip Code:_____
Place of Employment: _____ Cell #:_____

Father/Guardian: _____Address: _____
City:_____State:___Zip Code:_____
Place of Employment: _____ Cell #:_____

Emergency Contact (other than parent):
Name:_____ Relationship:_____ Phone #:_____
Name:_____ Relationship:_____ Phone #:_____

***Phone Numbers are required to complete your child's application

Other person(s) you permit to pick up your child:
Name:_____ Name:_____
Name:_____ Name:_____

PARENTAL PERMISSION: I give my child permission to participate in Child Care activities including field trips that may occur as part of the program. USTC Branch is also authorized to pick my child up from school.

X_____ _____
Parent/Guardian's Signature Date

Persons Authorized for Release of Child:

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Signature of Parent/Guardian: _____ Date:_____

School Age Child Care Service - Medical History-Health Record

Child's Name: _____
Age: _____ Birth Date: _____

Address: (Street and Number): _____

City: _____ State: _____ Zip: _____

Please note: In order for your child to attend any day care center in Rhode Island, you must provide an immunization record and evidence of a pre-admission physical examination by a licensed physician.

Please complete the information below and attach the physical examination and immunization record.

Health History: (Check if this is an issue and explain so that staff is aware)

Frequent Colds? _____
Frequent Sore Throats? _____
Stomach Upsets? _____
Ivy, Oak, Sumac Poisoning? _____
Allergies (Bee sting, etc.)? _____

Has your child had a tuberculin skin test? (Check one) Yes No

If yes, indicate: Date: _____ Positive: Negative:

Medications currently being taken: _____

Are there any conditions which should be brought to the attention of the staff?

_____

Parent/Provider Enrollment Agreement

Rev. 2/2020

Rhode Island Department of Human Services
Office of Child Care
25 Howard Avenue, LP Bldg. 3rd Floor
Cranston, R.I. 02920
(401) 462-6877

This form is to be used by the parent and the provider when enrolling a CCAP eligible or potentially eligible child at an approved DHS provider. One form must be completed per enrolled child. It must be completed and signed by the parent **and** the child care provider; a copy is to be kept by both parties. It is the **provider's responsibility** to submit this information to DHS via the Provider Portal **BEFORE** the provider begins caring for the child. Once the enrollment is complete, the parent and the provider will receive an Enrollment notice.

Provider ID:	178 603	**Provider Name:**	MK Taekwondo Inc DBA USTC Branch
Parent's Full Name:		**Certificate Number:**	
Child's Full Name:		**Child's DOB:**	

Are you related to the child? __ Yes / __ No

AGREED HOURS OF CARE					
Care Start Date: Care End Date:				Use this section when child's schedule is a split day	
Day	Start Time	End Time		Start Time	End Time
Sunday					
Monday	6 am	9 am		2 pm	6 pm
Tuesday	6 am	9 am		2 pm	6 pm
Wednesday	6 am	9 am		2 pm	6 pm
Thursday	6 am	9 am		2 pm	6 pm
Friday	6 am	9 am		2 pm	6 pm
Saturday					

The undersigned Provider, hereafter referred to as "Provider" agrees to care for the above-named child for the period indicated in this enrollment. Provider further agrees that the days and times the child will attend were agreed upon by the Provider and the undersigned parent of the child. **The undersigned parent certifies that the hours of this enrollment correspond to the hours DHS Authorized hours.**

The Provider agrees to accept the DHS payment based upon the DHS authorization and approval for Full Time, Three Quarter Time, Half Time, Quarter Time or Before and/or After School Care as payment in full and understand that any services provided in excess of authorized hours shall be the sole responsibility of the parent. Provider understands and agrees to accept this payment in accordance with DHS rules and regulations lawfully promulgated in accordance with R.I. General Laws. The Provider agrees to provide child care in accordance with the DHS rules and regulations and in accordance with the DHS CCAP Approved Provider Agreement.

The undersigned parent agrees to pay his/her share of the child care cost in accordance with the RI DHS rules and regulations and specified in the notice sent by the RI DHS Child Care Assistance Program.

The Provider and the undersigned parent certify that they DO NOT live in the same household.

Signature of Parent Michael Kang Sr Verified by pdfFiller 08/25/2025 — **Date**

Signature of Provider — **Date**

Michael Kang Sr — Program Administrator

Provider Printed Name — **Position/Title**

Rhode Island Department of Human Services

Licensed Child Care: Child Information Form

Updated 2/2023

Child Information					
Child's Full Name:		**Enrollment Date:**			
Date of Birth (MM/DD/YYYY):		**Sex:**	☐ Male ☐Female		
Primary Language:		**Secondary Language:**			
Primary Address					
Number and Street:					
City/Town:		**State:**		**Zip:**	
School Information	☐ N/A (Child does not attend an additional program)				
School/Program Name:		**Phone:**	( ) -		
Number and Street:					
City/Town:		**State:**		**Zip:**	
Parent/Guardian 1 Information					
Parent/Guardian Full Name:					
Parent/Guardian Role:	☐ Mother/Father ☐ Step-Mother/Step-Father ☐ Foster Parent ☐ Other: _____				
Contact Information					
Primary Phone:	( ) -	☐ Mobile ☐ Work ☐ Home			
Secondary Phone:	( ) -	☐ Mobile ☐ Work ☐ Home			
Email:					
Home Address			☐ Same as Child		
Number and Street:					
City/Town:		**State:**		**Zip:**	
Employer Information					
Employer Name:					
Address:					
City/Town:		**State:**		**Zip:**	

Typical Schedule

Day:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Hours:							

Child Information Form

Child's Name: _____

Parent/Guardian 2 Information							
Parent/Guardian Full Name:							
Parent/Guardian Role:	☐ Mother/Father ☐ Step Mother/Step Father ☐ Foster Parent ☐ Other: _____						
Contact Information							
Primary Phone:	( ) -			☐ Mobile ☐ Work ☐ Home			
Secondary Phone:	( ) -			☐ Mobile ☐ Work ☐ Home			
Email:							
Home Address				☐ Same as Child			
Number and Street:							
City/Town:		**State:**		**Zip:**			
Employer Information							
Employer Name:							
Address:							
City/Town:		**State:**		**Zip:**			
Typical Schedule							
Day:	**Sunday**	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
Hours:							

Additional Members of Child's Household			
Full Name:		**Relationship:**	
Full Name:		**Relationship:**	
Full Name:		**Relationship:**	
Full Name:		**Relationship:**	
Full Name:		**Relationship:**	

Additional Child Information	
It is recommended that this form is copied and provided to the child's direct teacher/provider.	
Social-Emotional	
Child's Habits:	
Child's Fears:	

Child Information Form

Child's Name: _____

Additional Child Information	
It is recommended that this form is copied and provided to the child's direct teacher/provider.	
Favorite Toys/ Activities/Interests:	
How do you comfort your child?	
How do you guide your child's behavior?	
Can you provide me with any additional information about your child which might help in caring for him/her?	

Bathroom Habits			
Is your child potty trained?	☐ Yes ☐ No ☐ So close!	**Does your child tell you when they have to use the bathroom? If so, how?**	
Is your child prone to diaper rash?	☐ Yes ☐ No	**What do you use to treat diaper rash?**	☐ Lotion ☐ Oil ☐ Powder ☐ Other:

Sleeping Habits			
Is your child sleep in a crib?	☐ Yes ☐ No	**Typical nap/time and/or nap habits:**	

Health	
Special physical conditions and/or disabilities:	☐ Yes: If yes, please explain: ☐ No
Regular medications:	☐ Yes: If yes, please explain: ☐ No
Allergies:	☐ Yes: If yes, please complete an Allergy Information Sheet. ☐ No

Child Care Schedule							
Day:	**Sunday**	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
Arrive:	**AM / PM**	**AM / PM**	**AM / PM**	**AM / PM**	**AM / PM**	**AM / PM**	**AM / PM**
Depart:	**AM / PM**	**AM / PM**	**AM / PM**	**AM / PM**	**AM / PM**	**AM / PM**	**AM / PM**

Child Information Form

Child's Name: _____

You must keep to this child care schedule. If at any time, your hours change and you need different hours of care, it is your responsibility to resubmit this information form with the correct hours.

Parental Access Restrictions
If there are temporary or permanent restrictions on a person's access to their child, please read and complete this section thoroughly. Please note: If the restricted person(s) are a child's biological parent(s), in order to abide by the permissions stated below, programs MUST have received a copy of any/all court documentations regarding restraining orders, physical/legal custody, joint custody, etc. Without court documentation, programs/providers are unable to withhold a child from their biological parent.

Restricted Person's Name:		**Relation to Child:**	

The above stated person has permission to see the child on the following days:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Acknowledgment
By signing this form, I acknowledge that the information contained in this document is true and accurate. I understand that it is my responsibility to update the program/provider in the event of any changes or updates to the information in this form.

Parent/Guardian Name (Print)	**Relation to Child**
Parent/Guardian Signature	**Date**