GRESHAM HEIGHTS LEARNING CENTER, LLC

Enrollment Application

Please print completely and legibly

Child's Name: _____
(Last Name) (First) (Nickname) (Middle Initial)

Child's Address: _____

City: _____ State: _____ Zip: _____ Phone #: (503)_____-_____

Date of Birth: _____-_____-_____ Sex: Male ☐ Female ☐ First Day of Enrollment _____-_____-_____
(Month) (Day) (Year) (Month) (Day) (Year)

Circle days to attend: Mon. Tues. Wed. Thurs. Fri. (Aprox) Arrival Time: _____ Departure Time:_____

Name of Grade School _____ District_____

Grade Entering in Fall _____ Time School Starts: **AM**: _____ _ Time School Ends: PM:_____

Parent Information:

Enrolling Parent/Guardian: _____
(Last Name) (First Name) (Middle)

E-mail Address: _____@_____

Relationship to Child: _____Phone #: (503)_____-_____

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

Employer: _____Work Phone #: (503)_____-_____ ex: ___

Work Address: _____ City: _____ State: ____ Zip: _____

Work Hours: _____Mobile Phone #: (503) _____-_____

Driver's License #: _____Social Security #: _____

Parent/Guardian: _____
(Last Name) (First Name) (Middle)

E-mail Address: _____@_____

Relationship to Child: _____Phone #: (503) _____-_____

Address: _____City: _____ State: ____ Zip: _____

Employer: _____Work Phone #: (503)_____-_____ ex: ___

Work Address: _____City: _____ State: ____ Zip: _____

Work Hours: _____ Mobile Phone #: (503)_____-_____

Driver's License #: _____ Social Security #: _____

Primary Residence: ☐ With Mother ☐ with Father ☐ with Both ☐ with Guardian (Name): _____

Parent's Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Enrollment Application
(Continued)

If divorced, who has legal custody? _____

May the non-custodial parent pick up the child? Yes No
(If yes, include name in release below. If no, Documentation from the court may be required.)

The child will be released only to the people on this application and the following persons:

Name: _____ **Phone # (503)** _____-_____

Name: _____ **Phone # (503)** _____-_____

Name: _____ **Phone # (503)** _____-_____

Child's Physician: _____ Phone # (503) _____-_____

Address: _____ City _____ State_____ Zip _____

Child's Dentist: (If applicable) _____ Phone # (503) _____-_____

Address: _____ City _____ State_____ Zip _____

Any allergies or special needs? Yes No If yes, what_____

If Mother or Father cannot be reached in an emergency, please Call:

Name: _____ Phone # (503) _____-_____

Address: _____ City _____ State _____ Zip _____

Hospital Preference: _____

In an **emergency**, **Gresham Heights Learning Center has my permission to call an ambulance or go to a physician at my expense. Yes or No**

Is your child currently on any **medications**? Yes No If yes, Name/reason? _____

My child may be taken on **field trips** by walks, bus, van, or other private motor vehicles under proper supervision. **Yes** **No**
My child may have his/her **picture taken** and used for publicity or news purposes. **Yes** **No**

Parent Agreement

____ Monthly tuition is due by the end of month. All balances not paid by the 5th of the following month will have a $25 late fee applied to account. $ 20.00 fee on all checks returned NSF.
____ Failure to pay any unpaid balance by the 10th of the following month will result in termination of services & legal action at my expense.
____ I agree to provide a credit card on file.
____ I will provide a 2-week notice to discontinue service.
____ A $1 per minute per child will be charged for late pick-ups after 6:00pm.
____ I agree to pay a $55.00 non-refundable registration fee at the time of enrollment per child.
____ I agree to pay a renewal fee of $55.00 every September.
____ I give permission for transportation to and from school in any licensed GHLC vehicle.
____ I acknowledge that the policies and procedures at GHLC is available upon request.

_____ _____
(SIGNATURE OF PARENT OR GUARDIAN) **(DATE)**

*THIS FORM MUST BE COMPLETED AND RETURNED **ON OR BEFORE** THE FIRST DAY OF ATTENDANCE. THANK-YOU!*

GRESHAM HEIGHTS LEARNING CENTER, L.L.C.
EMERGENCY CONSENT FORM

If your child needs emergency medical care and you aren't available to give formal consent to medical authorities, care may be unnecessarily delayed. To protect your child, leave a completed EMERGENCY CONSENT FORM WITH YOUR BABYSITTER, CHILDCARE PROVIDER, OR TEMPORARY GUARDIAN. In the event of a medical emergency, the form should accompany your child to the hospital / clinic so that medical treatment can be rendered.

I / we hereby authorize Gresham Heights Learning Center LLC. To give consent for all Transportation, Medical and/or surgical treatment that may be required for our child/children during our absence from

_____Until_____

We will have you renew this form once a year.

Child's name	Date of birth	Chronic illness	allergies	Current medications	Date of last tetanus immunization

COMMENTS: _____

Physician: _____Telephone:_____

Name and address of Parent/Guardian: _____

_____telephone:_____

Employer: _____ telephone:_____

Health Insurance Co. _____Member No:_____

Group No: _____Telephone:_____

Nearest Relative: _____telephone:_____

Signed, Parent/Guardian_____Date:_____

Signature Update:_____Date:_____

Signature Update:_____Date:_____

Signature Update:_____Date:_____

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled at a child care center. **Gresham Heights Learning Center** offers healthy meals to all enrolled children as part of our participation in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). The CACFP provides reimbursements for healthy meals and snacks served to children enrolled in child care. Please help us comply with the requirements of the CACFP by completing the attached Confidential Income Statement. In addition, by filling out this form, we will be able to determine if your child(ren) qualifies for free or reduced price meals.

1. **Do I need to fill out a Confidential Income Statement for each of my children in day care?** Complete and submit one CACFP Confidential Income Statement for all children in your household **only** if they are enrolled in the same center. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. **Return the completed form to: Gresham Heights Learning Center, 2300 NW Division St Gresham, OR 97030, 503-667-5198.**

2. **Who is eligible for free meals without providing income information?** Children in households getting Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR) are eligible for free meals. Foster children and children enrolled in Head Start based on income are also eligible for free meals. Children in households participating in WIC may be eligible for free meals.

3. **Who can get reduced price meals?** Your children can get low-cost meals if your household income is within the reduced price limits on the Federal Income Guidelines shown on this application. Children in households participating in WIC may be eligible for reduced price meals.

4. **May I fill out a form if someone in my household is not a U.S. citizen?** Yes. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the center or the day care home.

5. **Who should I include as members of my household?** You must include all people in your household (such as grandparents, other relatives, or friends who live with you) who shares income and expenses. You must include yourself and all children who live with you. You also may include foster children who live with you.

6. **How do I report income information and changes in employment status?** The income you report must be the total gross income listed by source for each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Federal Income Guidelines, the family day care home or center will receive a higher level of reimbursement. Once properly approved for free or reduced price benefits, whether through income or providing a current SNAP, TANF, FDPIR case number, you will remain eligible for those benefits for a period not to exceed 12 months. You should, however, notify us if you or someone in your household becomes unemployed and the loss of income during the period of unemployment causes your household income to be within the eligibility guidelines.

7. **What if my income is not always the same?** List the amount that you normally earn. For example, if you normally earn $1000 each month, but you missed some work last month and only earned $900, put down that you earn $1000 per month. If you normally earn overtime, include it, but not if you only earn it sometimes.

8. **What if I have foster child(ren)?** Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on the confidential Income Statement, but are not required to include payments received for the foster child as income. Households wishing to apply for such benefits for foster children should contact **Gresham Heights Learning Center, 2300 NW Division St Gresham, OR 97030, 503-667-5198.**

9. **We are in the military; do we include our housing and supplemental allowances as income?** If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.

10. **Centers charging for meals only (Pricing programs only). Will the information I provide be verified?** Maybe. We may ask you to send written proof to verify the information you submitted on the form. **What if I disagree with the decision about the information I complete on this form?** You should talk to your sponsoring organization. You may ask for a hearing by calling or writing to: **Gresham Heights Learning Center, 2300 NW Division St Gresham, OR 97030, 503-667-5198.**

In the operation of child feeding programs, no person will be discriminated against because of race, color, national origin, sex, age or disability.

If you have other questions or need help, call **503-667-5198.**

Sincerely,

OMER Roster Number ________

Child and Adult Care Food Program CHILD ENROLLMENT FORM

Child Care Centers/Head Start Programs

Gresham Heights Learning Center

CACFP Sponsor Name/Site Name

TO BE COMPLETED BY PARENT/GUARDIAN ONLY

The CACFP reimburses centers for serving nutritious, well-balanced meals and snacks to children in care.
Complete the following chart for all children in care. Sign, date, and return to the center. Use additional forms, as needed.
Parents/guardians of all infants must complete the Infant Formula Selection section.

Children's Names	Normal Hours in Care: Enter the **time** your child usually *arrives* each day.	Normal Hours in Care: Enter the **time** your child usually *leaves* each day.	Normal Meals and Normal Days in Care
Last:			**Normal Meals While In Care** Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐
First	Time ☐ AM ☐ PM	Time ☐ AM ☐ PM	**Normal Days of the Week in Attendance** Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun ☐
Last			**Normal Meals While In Care** Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐
First	Time ☐ AM ☐ PM	Time ☐ AM ☐ PM	**Normal Days of the Week in Attendance** Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun ☐
Last			**Normal Meals While In Care** Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐
First	Time ☐ AM ☐ PM	Time ☐ AM ☐ PM	**Normal Days of the Week in Attendance** Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun ☐
Last			**Normal Meals While In Care** Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐
First	Time ☐ AM ☐ PM	Time ☐ AM ☐ PM	**Normal Days of the Week in Attendance** Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun ☐

Parent/Guardian Print Name: ____ Date ____________

Parent/Guardian Signature: ____

INFANT FORMULA SELECTION: Complete if any child listed above is an infant under one year of age

This center provides ______________________________ (list brand) iron fortified infant formula.

Check one: ☐ I accept the center provided formula
☐ I decline the center provided formula
I understand that by declining the center provided formula, I agree to provide breast milk or formula for my child.
If I provide formula it must be on the approved formula list for the center to be reimbursed for the meal.

Updates: *(annual at a minimum)*	The parent/guardian signing this form certifies that the enrollment information is correct. If information has changed, the parent/guardian has written the appropriate changes on the form and initialed the change. *If there are many changes, please complete a new form.*	
First Update	*Parent/Guardian Signature*	*Date*
Second Update	*Parent/Guardian Signature*	*Date*
Third Update	*Parent/Guardian Signature*	*Date*
Fourth Update	*Parent/Guardian Signature*	*Date*

USDA and this institution are equal opportunity providers and employers.

OMER Roster Number _____

2020-2021 CONFIDENTIAL INCOME STATEMENT – Child Care Centers/Family Day Care Providers

INSTRUCTIONS:

- If your household received SNAP, TANF or FDPIR, complete parts 1-3, and 5; part 6 is optional.
- If you do not receive these benefits and your income is below the guidelines (back) complete parts 1, 2, 4, and 5; part 6 is optional.
- If you are applying for a FOSTER CHILD only, complete parts 1, 2, and 5; part 6 is optional.

Any income fields left blank will be counted as zeros. Please be careful that you meant to leave income fields blank.

1 HOUSEHOLD INFORMATION

Print name of person completing this application (Last name, First name)

_____
Name **Print**

_____
Mailing Address – Apt #

_____
City State Zip

Home Phone or Cell Phone (Circle One)

_____
Work Phone

➔ Number living in this household _____
(Write names of **all** household members on part 2 and/or part 4 of this form)

2 CHILD INFORMATION – (Names of Your Children *Enrolled* in Child Care)

	Child's Name (Legal Last name, First name)	Birth Date	Age	Check if Foster Child (placed by welfare agency or court) If only foster care child(ren) see instructions above
1.				☐
2.				☐
3.				☐

3 PUBLIC BENEFITS Indicate which **benefits** your household currently receives, and list case number, if any:

Name: _____ Case Number: _____

☐ SNAP (Supplemental Nutrition Assistance Program) (*Oregon Trail Card number not acceptable*)
☐ TANF (Temporary Assistance to Needy Families) (*Employment Related Day Care does not qualify*)
☐ FDPIR (Food Distribution on Indian Reservations)

4 HOUSEHOLD MEMBERS & GROSS MONTHLY INCOME – if not monthly, see back for conversions

	Column 1 List **all** household members, including children not attending school, and income. Do not include children listed in part 2, unless they receive regular income. (*Last name, first name*)	Column 2 MONTHLY INCOME (Total earnings & wages before deductions)	Column 3 MONTHLY CHILD SUPPORT, WELFARE, ALIMONY RECEIVED	Column 4 MONTHLY PENSIONS, SOCIAL SEC., RETIREMENT, SSI, VA	Column 5 OTHER MONTHLY INCOME -Including unemployment and workers comp.	Column 6 Check if No Income
1.						☐
2.						☐
3.						☐
4.						☐
5.						☐
6.						☐
7.						☐

5 SIGNATURE, DATE and Last four numbers of SOCIAL SECURITY NUMBER (Adult must sign)

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.

Signature of Adult Household Member

X _____

Date Signed

_____
Month/day/year

Social Security Number
(See privacy statement on back)
XXX-XX - ___ ___ ___ ___

☐ **I do not have a Social Security Number.**

6 RACIAL OR ETHNIC GROUP (OPTIONAL)

Mark one ethnic identity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Mark one or more racial identities:
☐ Asian
☐ American Indian & Alaskan Native
☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American
☐ White
☐ Other

SPONSOR USE ONLY - DO NOT WRITE BELOW THIS LINE

Total Income:_____ Number in Household:_____

Centers
Eligibility : ☐Free ☐Reduced Price ☐Above Scale

FDCH
☐Tier 1 ☐Tier 2

Eligibility based on : ☐SNAP ☐TANF ☐ FDPIR ☐Household Income ☐ Foster Child

Notes: _____

Determining Official's Signature :_____ Date_____

Second Check Signature: _____ Date_____

SEE IMPORTANT INFORMATION ON REVERSE SIDE

DETERMINING MONTHLY INCOME FOR EARNINGS & WAGES

Monthly income for all household members must be reported in Section 4 of this application. Income means any money regularly received from work, child support, alimony, pensions, retirements, social security or any other source. Exclude student/school loans. Money received from a business or farm owned by you should be reported as "net income". *Net Income is defined as the total income left after business and farm operating expenses are subtracted from gross receipts.*

Homeless, migrant and runaway youth are categorically eligible for free meals.

Household members who are not paid monthly should change earnings into monthly income by doing the following:

Household members who are paid every week: Multiply total earnings and wages for one pay period, before deductions, by 52. Then divide by 12. The resulting amount is the total monthly income.

Household members who are paid every 2 weeks: Multiply total earnings and wages for one pay period, before deductions, by 26. Then divide by 12. The resulting amount is the total monthly income.

Household members who are paid twice a month: Multiply total earnings and wages for one pay period, before deductions, by 24 then divide by 12. The resulting amount is the total monthly income.

Household members who are seasonal workers or work less than 12 months: Project annual rate of income to accurately represent actual circumstances then divide by 12. The resulting amount is the projected monthly income.

FEDERAL INCOME GUIDELINES

Your children may qualify at least for reduced price meals if your household income falls within the limits of this chart.

	Reduced Price Meals				
Household Size	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
-1-	23,606	1,968	984	908	454
-2-	31,894	2,658	1,329	1,227	614
-3-	40,182	3,349	1,675	1,546	773
-4-	48,470	4,040	2,020	1,865	933
-5-	56,758	4,730	2,365	2,183	1,092
-6-	65,046	5,421	2,711	2,502	1,251
-7-	73,334	6,112	3,056	2,821	1,411
-8-	81,622	6,802	3,401	3,140	1,570
For each additional family member add	8,288	691	346	319	160

PRIVACY STATEMENT - SOCIAL SECURITY NUMBERS and OTHER INFORMATION

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 your child for free or reduced price meals. You must include the last 4 digits of the social security number of the adult household member who signs the application. The last 4 digits of 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 case number or Food Distribution Program on Indian Reservations (FDPIR) identifier for your child 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 your child is eligible for free or reduced price meals and for administration and enforcement of the lunch and breakfast programs. We **may** share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs; auditors for program reviews; and law enforcement officials to help them look into violations of program rules. We may share the information on this form with Medicaid or the State Children's Health Insurance Program (SCHIP), unless you tell us not to. The information, if disclosed, will only be used to identify eligible children and seek to enroll them in Medicaid or SCHIP.

NON-DISCRIMINATION STATEMENT

This explains what to do if you believe you have been treated unfairly. In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: 1) mail: U.S. Department of Agriculture ,Office of the Assistant Secretary for Civil Rights,1400 Independence Avenue, SW ,Washington, D.C. 20250-9410; 2) fax: (202) 690-7442; or 3) email: program.intake@usda.gov

This institution is an equal opportunity provider.

Gresham Heights Learning Center
2300 NW Division St.
Gresham, OR 97030
503-667-5198

Special Transportation Arrangement:

The Office of Childcare requires a written plan for the transportation arrangement between the Childcare Facility and the parent or guardian of the child. The following indicates the Childcare Facility's transportation plan:

Child's name:_____

Child's school:_____

They will be transported/escorted between the childcare facility and the school by: (check applicable)

___School bus **___Head Start bus** **___Childcare Facility**

___Arrive/Depart unescorted with permission

If my child is not at the designated pickup site, Gresham Heights Learning Center will call the child's parent or guardian.

There will be a $5.00 charge for any child that is scheduled to be picked up or ride the bus, that is not at the designated pick up spot without prior call to Gresham Heights Learning Center.

I understand that Gresham Heights Learning Center is not responsible for my Child until they are picked up by Gresham Heights Learning Center or dropped off by the school bus.

_____

Parent/Guardian Signature **date**

Medical Authorization for Non-Prescribed Medications

Child's Name: _____

All over the counter medications including topical substances shall be in the original container and labeled with the child's name. My child may be given non-prescribed medication. This may include the following:

Acetaminophen	☐ Yes ☐ No	Ibuprofen	☐ Yes ☐ No
Antibiotic cream	☐ Yes ☐ No	Insect Repellent	☐ Yes ☐ No
Antihistamine	☐ Yes ☐ No	Lip Balm	☐ Yes ☐ No
Antiseptic wipes/gel	☐ Yes ☐ No	Rash Ointment/Cream	☐ Yes ☐ No
Baby Lotion	☐ Yes ☐ No	Saline Nose Drops	☐ Yes ☐ No
Baby Oil	☐ Yes ☐ No	Shampoo	☐ Yes ☐ No
Baby Powder	☐ Yes ☐ No	Sunburn Ointment	☐ Yes ☐ No
Cough Syrup	☐ Yes ☐ No	Sunscreen	☐ Yes ☐ No
Diapering Ointment	☐ Yes ☐ No	Teething medications	☐ Yes ☐ No
Diaper Wipes	☐ Yes ☐ No	Toothpaste	☐ Yes ☐ No
Hydrocortisone	☐ Yes ☐ No	Petroleum Jelly	☐ Yes ☐ No

Other: _____

_____

_____

_____

_____

_____

_____ _____

Parent/Guardian's Signature Date

_____

Parent/Guardian's Printed Name

Health, Housing & Human Services
CLACKAMAS COUNTY

Multnomah County
Health Department

WASHINGTON COUNTY
OREGON
Department of Health and Human Services

Exclusion Guidelines for Schools and Child Care Settings
Clackamas, Multnomah and Washington Counties*

Does the student have any of the following?

- ☐ Diarrhea: At least 3 loose stools in 24 hours – *OR* – sudden onset of loose stools.
- ☐ Vomiting: At least one episode that is unexplained in the past 24 hours.
- ☐ Fever: A body temperature of at least 100.4
- ☐ New skin rash, sores or wounds: Not previously diagnosed by a health care provider

NO → **OK to attend school or day care**

YES

For Diarrhea or Vomiting
Stay at Home --
Until symptoms are gone for 24 hours;
DO NOT handle any shared food until 72 hours after symptoms are gone.

For Fever
Stay at Home --
Until fever is below 100.4 for 24 hours **WITHOUT** the use of fever-reducing drugs *(for example, Tylenol, acetaminophen, Advil, Motrin, ibuprofen)*

For Skin Rash, Sores or Wounds:
Stay at Home –
- If rash is increasing in size, or if new sores or wounds are developing day-to-day, ***– OR –***
- If rash, sores or wounds are draining and cannot be completely covered with a bandage.

No contact sports until sores or wounds are healed or no longer draining

When to report to local health department
- **Report any suspected outbreak or reportable disease immediately.** A suspect outbreak means a higher than expected number of students or staff sick with similar symptoms around the same time.
- **Report any suspected outbreak or reportable disease to the school nurse.** If a school nurse is not available, contact the County Health Department.
- See Oregon Disease Reporting Guidelines Online for a list of diseases and reporting timelines. http://www.co.washington.or.us/HHS/CommunicableDiseases/upload/Disease_Exclusion_Guide_Updated-July-2017-1.pdf

Questions? Contact Washington County Public Health Department: 503-846-3594

*Please contact the school nurse or county health department if you have questions.

Last Updated: 10/02/2018

Child's name: _____ Parent Signature: _____ Date: _____

Gresham Heights Family,

New State Law put into effect by the Office of Child Care states that parents are to be given a written plan of emergency by their childcare provider. GHLC Emergency Plan is as followed:

Gresham Heights Learning Center keeps on record all parents current phone numbers and email address. If yours has expired, please make a correction with the front desk as soon as possible.

In the event of a fire, Gresham Heights Staff will evacuate the building and take all children up to the sidewalk in front of daycare. Once there, Parents or Emergency Contacts will be contacted via email or by phone for further direction.

In the event of a Natural Disaster, Gresham Heights Staff will escort the children to a safe place free of harm. Once there, Parents or Emergency Contacts will be contacted via email or by phone for further direction. Also please check your local news channel.

In the event of a Lock Down, Please DO NOT COME TO GRESHAM HEIGHTS LEARNING CENTER. Please leave the phone lines open and wait for Gresham Heights Learning Center to contact you. When the building is secure and police have given the all clear, Parents or Emergency Contacts will be contacted via email or by phone for further direction. Also please check your local news channel.

Thank You
Gresham Heights Staff
Victoria@steppingstonedc.com
503-465-0030