



Child's Name _____

Date of Birth: _____ Date of Enrollment: _____

Gender: _____ Native Language: _____

Lives with: 2 parents 1 parent grandparents foster Other

Payment: Self Pay Vouchers Workforce Other

Date Of Withdrawal: _____

Child Information

My child has (check all that apply)

__ Siblings # _____ List Names: _____

__ Allergies __ Special Diet __ A Medical Plan __ Social/emotional needs __ An IEP __ Special Needs

Please Explain: _____

A History of: Measles _____ Mumps _____ German Measles _____ Chicken Pox _____ Whooping Cough _____
Seizures _____ Biting: _____ Defective Heart _____ Diabetes _____ Sun Sensitivity _____ Frequent Colds _____ Fainting Spells _____

Temper Tantrums _____ Contracted Tuberculosis _____ Frequent Ear Infections _____ Frequent Throat Infections: _____ Is

there a custody agreement or restraining order pertaining to this child? Yes No

A copy of any paper regarding custody must be on file with the school in order to enforce the order.

Schedule of Care—Please be as accurate as possible to help plan for staffing

Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Drop Off Time						
Pick up Time						

Family Information

Primary Caregiver: _____ Relationship to child: _____

Home Address: _____ City, State, Zip: _____

Primary Phone: _____ Email Address: _____

Place of employment: _____ Work Phone: _____ Work hours: _____

4 Digit Door Code _____

Secondary Caregiver: _____ Relationship to child: _____

Home Address: _____ City, State, Zip: _____

Primary Phone: _____ Email Address: _____

Place of employment: _____ Work Phone: _____ Work hours: _____

4 Digit Door Code _____

Emergency Contact

Name of person to call if parents cannot be reached: _____

Home Address: _____ City, State, Zip: _____

Relationship: _____ Primary Phone: _____ Work Phone: _____

Is this person authorized to take the child from the center? Yes _____ No _____ 4 Digit Door Code _____

PickUp List

List all other adults who are authorized to take child from the center:

Name: _____ Relationship to Child: _____ Phone: _____

Name: _____ Relationship to Child: _____ Phone: _____

Name: _____ Relationship to Child: _____ Phone: _____

Name: _____ Relationship to Child: _____ Phone: _____

Person's specifically **NOT** authorized to pick up child (MUST provide legal documentation if person is a parent)

Name: _____ Relationship to Child: _____

Name: _____ Relationship to Child: _____

Medical Information

Child's Physician or emergency treatment facility

Phone number

Address

City, State, Zip

I, _____, mother father guardian

of _____ hereby give my consent to the
(Child's Name)

Director/Assistant Director of Little Martians, or their duly representative, for said child to receive medical or surgical aid as may be deemed necessary to expedient by a duly licensed or recognized physician or surgeon in case of an emergency when transport said child for emergency medical treatment, if the parents cannot be reached.

Parent / Guardian Signature

Date

Witness Signature

Date

HIPPA Release Form

HIPAA Release Form Allergy and Medical Postings

I, _____, parent/guardian of _____
(Print Name) (Print Child's Name)

Authorize Little Martians to post my child's allergy/medical alert in his/her assigned classroom, in the kitchen, and other areas as needed. I understand that this information will be posted to ensure all staff members are aware of my child's allergy/medical needs.

Parent/Guardian's Signature

Date

Consents

① I hereby give ___ do not give ___ the Director of the Child Care Facility or his appointed representative permission to give _____ acetaminophen. I understand I will be notified that the medication has been administered.

Signature _____ Date: _____

② I hereby give ___/do not give ___ written permission for the use of suntan lotions/sunscreen for my child in permitable weather. School age children may apply sunscreen to themselves. In accordance with Minimum Licensing Requirements: DCCECE/Child Care Licensing unit : 1100.1101.17.

Signature: _____ Date: _____

③ I hereby give ___/do not give ___ the child care facility permission to take photographs of my child for use in the facility.

Signature: _____ Date: _____

④ I hereby give ___/do not give ___ the child care facility permission to take video recordings of my child for use in the facility.

Signature: _____ Date: _____

⑤ I hereby give ___/do not give ___ the child care facility permission to place photos of my child on social media or the facility website for community involvement or promotional purposes.

Signature: _____ Date: _____

⑥ I hereby give ___/do not give ___ the child care facility permission to place video recordings of my child on social media or the facility website for community involvement or promotional purposes.

Signature: _____ Date: _____

③ thru ⑥ In accordance with minimum licensing requirements: DCCECE/Child Care Licensing Unit: 600.604.1.k and l

Acknowledgments

① This is a statement of verification that I have been informed that the childcare licensing/child maltreatment investigators and/or law enforcement may possibly interview my child for the purpose of determining licensing compliance or for investigative purposes. In accordance with Minimum Licensing Requirements: DCCECE/Child Care Licensing Unit: 200.201.4
Signature: _____ Date _____

② This is a statement of verification that I have been informed of the behavior guidance policy practiced. In accordance with Minimum Licensing Requirements: DCCECE/Child Care Licensing Unit 500.501.7

Signature _____ Date _____

③ This is a statement of verification that I have received information regarding Shaken Baby Syndrome in accordance with Carter's Law (all parent's of infants) In accordance with Minimum Licensing Requirements: DCCECE/Child Care Licensing Unit: 600.604.1

Signature _____ Date _____

④ This is a statement of verification that I have received information about AR Kids 1st.

Signature _____ Date _____

⑤ This is a statement of verification that I have received a copy of the Kindergarten Readiness Indicators Checklist.

Signature _____ Date _____

⑥ I, The parent/ guardian of this child, understand that I may ask for a conference with the caregivers as needed

Signature _____ Date _____

⑦ I have received a copy of the handbook and agree to the policies therein.

Signature: _____ Date _____

Parent Agreement Form

Anyone wishing to enroll at Little Martians Learning Center must be able to abide by the following policies:

Tuition is due Friday for the following week. If tuition is not paid by the end of the business day on Monday your child will not be able to return to Little Martians Learning Center until it has been paid in full. There will be a \$25.00 per day, per child late fee assessed for late payments. Class placement is based on the age of the child. An updated immunization record must be on file for children ages 6 weeks to 5 years old.

Tuition remains the same for all weather related closings, holidays, absences and sick days. The facility generally follows Bentonville and Springdale School District for weather related conditions. Closings will be posted on the Little Martians Facebook page and emailed to parents. Each child receives, annually, 2 week tuition free vacation after the child has been enrolled for 90 days. A 2 week notice will be given to Little Martians Learning Center when a child will be absent due to a vacation. Tuition will be charged without this notice. Children must be dropped off no later than 8:45am. Any child dropped off later than 8:45am without a doctor's note and proper notification will be asked to stay home and return the following day.

Any child showing symptoms of illness will be isolated and the parent/guardian will be notified immediately to come pick up the child. Siblings that attend the center must also be picked up and remain out until the sick child is well. If the child is not picked up within an hour, a late fee will be charged. It is not within the center's abilities to assess a child's likely diagnosis. Arkansas Child Care Licensing mandates at what point and when we have to send a child home for illness. These mandates are in your parent handbook, please review them carefully as we will strictly adhere to them. A child should be free from fever, vomiting, diarrhea, etc. for a minimum of 24 hours and be able to participate in all activities including outdoor play before returning to Little Martians Learning Center.

Two changes of weather appropriate clothing will need to be provided to the facility by the child's parent or legal guardian for each child.

Any child who is not fully potty trained must bring to the center all necessary items (clothing, diapers, wipes, pull-ups, cream, etc.) to take care of the child's diapering/toileting. Items can be stored at the facility or sent in a bag daily. Infants will need bottles, formula, and baby food provided by their caregiver.

Children are not to bring coins, guns, knives, sharp objects, potentially dangerous items or toys to the facility. Sentimental/expensive items should not be sent. Little Martians Learning Center is not responsible for lost or stolen personal items. Children should be dressed appropriately for play and the weather. Little Martians Learning Center is not responsible for clothing damaged during daily play activities.

Parents and teachers will work closely to support Little Martians Learning Center's Behavior Policy to provide a safe and happy learning environment. A 2 weeks notice will be given to Little Martians Learning Center prior to withdrawing a child. Tuition will be charged and collected through the 2 weeks regardless of attendance. Children are subject to be interviewed without notice by licensing staff, child maltreatment investigators, or by law enforcement for investigative purposes and/or determining compliance with licensing requirements.

I have read and understand the Little Martians Learning Center Parent Agreement. I will comply with all of the policies stated.

Child's Name: _____

Parent/Guardian (print): _____

Parent/Guardian Signature: _____

Date: _____

Behavior

Guidance Policy

We believe that children's misbehavior is an opportunity for teaching. Our goal is to help children develop self-control and to understand appropriate behaviors. We use the following steps to guide children's behavior.

- ★ Help children know and understand limits for behavior and consistently implement limits.
- ★ Recognize and comment on desirable behaviors.
- ★ Teach social skills, problem-solving steps, and calm down routines as preventive measures.
- ★ Overlook minor incidents that are not dangerous or disruptive, allowing children opportunities to use the problem-solving steps.
- ★ When a situation requires adult assistance, help the child regain control of his/her emotions (if needed). Recognize the child's feelings and comfort the child. When the child is calm, identify the inappropriate behavior and how it is hurtful to the child, to others, and/or to the environment. Help the child think of appropriate behaviors that might have been used in that situation.
- ★ Direct the child to a different activity, if necessary.
- ★ Help the child calm down by briefly removing him/her from the group or activity where the inappropriate behavior occurred. Be sure the child understands why he/she is being removed. Identify the behavior that is expected when he/she returns to the group activity. Stay nearby to monitor. When the appropriate behavior occurs, immediately recognize and comment.
- ★ Briefly remove the child from the classroom under the supervision of a staff member, repeating the step above to teach, monitor, and recognize appropriate behavior.
- ★ If a pattern of inappropriate behavior develops or if the child's behavior results in destruction of equipment or injury to self or others, a conference with the parents will be required. Working together, we can develop a plan of action that will provide the support and resources needed to help the child.
- ★ There shall be no physical punishment or threat of physical punishment.
- ★ Each child's dignity will be maintained. Incidents will be handled calmly and in a positive, supportive manner.
- ★ Children under the age of two will not be placed in "time-out" as this age group does not understand or benefit from the consequence. Redirection and modeling desired behaviors are the guidance techniques used with this age group. Children will only be removed from activities when their behavior threatens the health or safety of the other children in the room



CHILD CARE FOOD PROGRAM
ENROLLMENT FORM
(to be completed by parent or guardian)

Provider's Initial: _____
Date: _____

You have chosen a daycare that participates on the USDA Child and Adult Care Food Program (CACFP). It is our goal to assist in providing your child with nutritious meals/snacks. This enrollment information may be verified. The meal times, the meal pattern and the daily menus should be posted and available for parents at all times. If you have questions, or comments, or would like to learn more about the Child and Adult Care Food Program, contact our office.

Name of Day Care Facility

Address

Telephone

Address

The following information is required by USDA Federal Regulation CFR 226.15(e)(2).

I wish to enroll my child(ren), whose names and enrollment information are given below, in the USDA Child and Adult Care Food Program. I understand this program reimburses day care facilities for serving nutritious, well balanced meals/snacks to day care children.

My child(ren) will be served the following meals:

(Please Check) Breakfast AM Snack Lunch PM Snack Supper Late Snack

Child(ren) Information (please print)

First Name	Last Name	Age	Birthdate	Hrs of Care	(check box) Days of Week			Gender
					M	T	W	
			/ /	from to	Th	F	Sa	M F
			/ /	from to	M	T	W	M F
			/ /	from to	Th	F	Sa	M F
			/ /	from to	M	T	W	M F
			/ /	from to	Th	F	Sa	M F

Note here any food allergies or special needs your child(ren) have: _____

Doctor's Name: _____ Doctor's Telephone: _____

Optional Information: Child(ren)'s racial/ethnic origin
__Hispanic/Latino __Am Indian/Alaskan Native __Black/African __White __Asian __Am Native Hawaiian or PI

I understand my child(ren) will receive meals at no extra charge to me when they are in care during any scheduled meal service and receive meals. I understand that the day care facility cannot and will not discriminate for reasons of race, color, national origin, sex, or disability. There is to be no discrimination in admission policy, meal service, or use of facility. Any complaints should be addressed to: USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

In case of emergency, please call: HOME # _____ WORK # _____

Parent Address: _____

Parent Signature: _____

Date: _____

(form valid one (1) year from this date)



CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM 2025-2026

Facility Name _____

Part 1. CHILDREN

LEGAL NAME OF ENROLLED CHILDREN	AGE	FOSTER CHILD YES - NO	ADDITIONAL HOUSEHOLD CHILDREN	AGE

Part 2. Benefits: If any member of your household received [State SNAP], [FDPIR], or [State TANF cash assistance], provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

CASEHEAD NAME: _____ CASE NUMBER: _____

A Case number is not the number found on the EBT card or an individual's Social Security number.

Part 3. If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call [Your School, Homeless Liaison, Migrant Coordinator at Phone #] Homeless ☐ Migrant ☐ Runaway ☐

Part 4. Total Household Gross Income: You must indicate amount & how often: weekly, bi-weekly, 2X month, monthly etc.

Names of all Other Household Members, (except the children above)	Earnings from work before deductions	Welfare, Child Support, Alimony	Pensions, SSI, VA Benefits, Social Security, Retirement	All other income	Check here if No Income
	\$ _____ ___ Weekly ___ Bi-Weekly ___ 2XMonth ___ Monthly	\$ _____ ___ Weekly ___ Bi-Weekly ___ 2XMonth ___ Monthly	\$ _____ ___ Weekly ___ Bi-Weekly ___ 2XMonth ___ Monthly	\$ _____ ___ Weekly ___ Bi-Weekly ___ 2XMonth ___ Monthly	
	\$ _____ ___ Weekly ___ Bi-Weekly ___ 2XMonth ___ Monthly	\$ _____ ___ Weekly ___ Bi-Weekly ___ 2XMonth ___ Monthly	\$ _____ ___ Weekly ___ Bi-Weekly ___ 2XMonth ___ Monthly	\$ _____ ___ Weekly ___ Bi-Weekly ___ 2XMonth ___ Monthly	
	\$ _____ ___ Weekly ___ Bi-Weekly ___ 2XMonth ___ Monthly	\$ _____ ___ Weekly ___ Bi-Weekly ___ 2XMonth ___ Monthly	\$ _____ ___ Weekly ___ Bi-Weekly ___ 2XMonth ___ Monthly	\$ _____ ___ Weekly ___ Bi-Weekly ___ 2XMonth ___ Monthly	
	\$ _____ ___ Weekly ___ Bi-Weekly ___ 2XMonth ___ Monthly	\$ _____ ___ Weekly ___ Bi-Weekly ___ 2XMonth ___ Monthly	\$ _____ ___ Weekly ___ Bi-Weekly ___ 2XMonth ___ Monthly	\$ _____ ___ Weekly ___ Bi-Weekly ___ 2XMonth ___ Monthly	

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 4 is completed, the adult signing the form must also list the last four digits of his/her Social Security Number or mark the "I do not have a Social Security Number" box.** (See back)

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: _____ (form valid for one (1) year from this date)

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

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

Facility Name: _____ Child's Name: _____

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

Mark one ethnic identity:	Mark one or more racial identities:	
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian or Alaska Native
<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> White	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
	<input type="checkbox"/> Black or African American	

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

Annual Income Conversion: Weekly x 52, Bi-Weekly x 26, 2X A Month x 24, Monthly x 12

Total Income: _____ Per: ☐ Week, ☐ Bi-Weekly, ☐ 2X Month, ☐ Monthly, ☐ Year Household size: _____

Categorical Eligibility: _____ Date Withdrawn: _____ Eligibility: Free _____ Reduced _____ Denied _____

Reason: _____

Determining Official's Signature: _____ Date: _____

If applicable, Sponsor Signature: _____ Date: _____

Income Conversion Chart – If Various Payment Methods are Indicated on Front

Weekly: \$ _____ X 52 = \$ _____ Total Yearly Income: _____

Bi-Weekly: \$ _____ X 26 = \$ _____ \$ _____

2X Month: \$ _____ X 24 = \$ _____

Monthly: \$ _____ X 12 = \$ _____

HNP Representative Initials/Date
(for use during CACFP Reviews)

Household Size	Yearly July 1, 2025 – June 30, 2026	
	Free (Maximum amount)	Reduced (Maximum amount)
1	\$20,345	\$28,953
2	\$27,495	\$39,128
3	\$34,645	\$49,303
4	\$41,795	\$59,478
5	\$48,945	\$69,653
6	\$56,095	\$79,828
7	\$63,245	\$90,003
8	\$70,395	\$100,178
Each additional person:	+\$7150	+\$10,175

The participant in the child care facility may qualify for free or reduced price meals if your household income falls within the maximum limits on this chart.

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, Assistant Secretary for Civil Rights, 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."

Please send copy of this form to AR Children at 6323 Ranch Drive Suite A Little Rock, AR 72223
Email – centers@AR-Children.com - Fax 1-501-737-8040



Obligation to Serve Infants in the CACFP

Dear Parents/Guardians:

This center/home/ministry participates in the Child and Adult Care Food Program (CACFP) and receives USDA reimbursement for serving nutritious meals to infant and children. Participation in this program requires caregivers to follow specific meal patterns according to the age of the child being fed.

Policy requires a center/home/ministry participating in the CACFP to offer formula and meals to infants who are in care during meal service times. Parents/guardians, however, may decline what is offered, and supply the infant's meals instead.

Please complete the following information:

Name of Provider/Child Care Center: _____

Type(s) of formula offered: _____

Name of Infant _____

Birth date _____

- ☐ I accept the type(s) of formula offered by my provider/childcare center/ministry.
- ☐ I declined the type(s) of formula offered by my provider/childcare center/ministry.
 - ☐ I will provide _____ formula/breast milk for my infant.
 - ☐ I will provide personal breast-feeding of my infant on-site at the facility.
Valid beginning October 1, 2017.
- ☐ I accept the meals and snacks offered by my provider/childcare center/ministry.
- ☐ I decline the meals and snacks offered by my provider/childcare center/ministry.

I will provide meals and snacks for my infant. Yes No

SIGNATURE OF PARENT/GUARDIAN

DATE

1. This form must be kept on file for each infant enrolled in childcare.
2. As situation change, such as a medical authority changing the infant's formula, a new form should be completed.
3. This form must be kept current and accurate for each infant enrolled for childcare until the infant reaches one year of age or is no longer on infant formula.
4. If the parent/guardian declines the formula and the provider provides meals and/or snack components, the meal may be claimed for reimbursement.
5. If the parent/guardian declines infant meals/snacks, meals and snacks may NOT be claimed for reimbursement.

REGIONAL THERAPY SERVICES



www.regionalthrapy.net

FREE DEVELOPMENTAL SCREENING AT LITTLE MARTIANS LEARNING CENTER

Birth to 6 years

We provide **free** developmental screenings to all children at Little Martians Learning Center to meet the better beginnings requirement. This is a great opportunity for parents and teachers to be informed of your child's skills necessary for normal development. These skills are vital to your child's educational experiences. We strive to ensure that children meet their full potential. You will receive information regarding your child's screening once it is completed- usually within 3-4 weeks. If your child needs services we can provide those services at your child's daycare facility. Feel free to contact us if you have further questions or concerns regarding your child's development. We are glad to serve children and families of Northwest Arkansas.

- Deedra Branscum, Lead Therapist, Call or text (479) 790-7979
- Meghan Delaney, B.S., Certified Child Development Specialist, Call or text (417) 343-2997 email screenings@regionalthrapy.net

Child's Name _____ Date of Birth _____

Parents Name _____ Phone # _____

Address _____ City _____ Zip Code _____

Insurance Type: Medicaid/AR Kids ___ yes ___ no Other Insurance Type _____

NOTE: We do not bill for the free screening service. This information is used to determine type of testing and qualifying criteria for the screening as different insurances have different requirements.

Child's main language: English ___ Other (please list) _____

Concerns:

Legal Guardian/Parent Signature

Date



Individual Care Information

Today's Date: ___/___/___ Birth date: ___/___/___

Child's Name: _____

***please mark N/A if it does not apply.**

Diapering & Toileting

Is your child potty-trained? _____ If not, please complete the following information:

How often do you change your child's diaper? _____

Are there any special instructions for diaper changes? _____

Is your child beginning to use the toilet? If so, are there any special instructions for toileting? (i.e. words used in toileting) _____

Sleeping

How often does your child take a nap? _____

What are some indicators he/she is tired? _____

What helps your child to fall asleep? (i.e. rocking, pacifier, special blanket, pat back, etc.)

Other helpful information

What comforts for him/her the best? _____

What are your child's likes and dislikes? _____

Are there any child rearing practices, values or cultural beliefs that you feel we need to know about? _____

Does your child have any fears? _____

Are there any physical or developmental concerns we should be aware of? _____

Is there anything special that we should know about dressing or undressing your child?

Please list the names and ages of the child's siblings and anyone else who lives in the home other than the parent or guardian:

Eating

Infants 6 weeks – 12 months:

Is your baby bottle-feeding or breast feeding? _____

If breast-feeding, how will you provide milk for your child? (i.e. frozen, bottles, etc.)

*You are more than welcome to come feed your child at the center at any time.

If bottle-feeding:

What kind of formula do you use? _____

How much is your child currently eating at a feeding? _____

At what temperature do you prepare it? _____

Is your child eating solid foods? ____ Yes ____ No

(*We like to introduce cereal by 4 months, baby food at 5-6 months, and table food by 7-8 months.)

If so, do you use homemade or store-bought food? _____

How do you prepare it? _____

What time of day do you feed him/her and how much does your baby usually eat?

Does he/she eat well from a spoon? _____

Does your baby eat any finger foods? If so, which ones? _____

Does your child drink from a sippy cup? ____ Yes ____ No

(*We introduce them when we start serving table foods at around 7-8 months)

Has your child been introduced to whole milk? ____ Yes ____ No

(*We like to introduce around 12 months)

All Children:

Is your child sensitive or allergic to any foods? If so, please list them.

Does your child have any chronic medical conditions? If so, please explain. _____

Do you authorize permission for your child to be photographed? Yes ____ No ____

Do you authorize permission for your child's photo to be put on LMLC social media pages? Yes ____ No ____



Automated Payment Processing Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR **BANK ACCOUNT** and **CREDIT CARD**

I (we) hereby authorize (business name) **Little Martians Learning Center Rogers** 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 - Select N/A on section NOT completed & sign.

SECTION A (Credit Card) - N/A

Cardholder Name	Phone #
Cardholder Address	City State Zip
Account Number	Expiration Date
Cardholder Signature	Date

SECTION B (Bank Account) - N/A

Your Name	Phone #	
Address	City State Zip	
Bank or Credit Union Name	Bank or Credit Union Address	City State Zip
Routing Transit Number (see sample below)	Account Number (see sample below)	<input type="checkbox"/> Checking <input type="checkbox"/> Savings
Authorized Signature	Date	

For Official Use Only

Date Received

Employee Signature

John Sample Mary Sample 123 Nice Street Anytown, USA	BANK OF THE WEST 555-555-5555	00226
Pay to the order of:	Attach Voided Check Here	\$
	Deposit slips not accepted	Dollars
123456789	1800330	0226
Routing Number	Account Number	Check Number

A service of



Protect Your Kid's Health.



Renew Your ARKid's Coverage Now.

If your child is on ARKids, you've probably received a letter telling you it is time to renew. The process has changed. We've made it simple to renew because we don't want your children to lose their health care coverage.

The fastest and easiest way to renew is online.

1. Go to www.access.arkansas.gov
2. Respond to the voter registration question with 'yes' or 'no'
3. On the next page, click the yellow button that says 'Log-In/Apply or Renew'
4. Then fill in the information requested.

If you do not want to renew online,
call or visit your local DHS office to get an
Application for Health Coverage.

1. Fill out the forms
2. Answer all questions
3. Sign page 8
4. Write **Renewal** across the top of the form
5. Mail the completed forms to:
DHS Pine Bluff Scanning Center
P.O. Box 5670
Pine Bluff, AR 71611

Don't delay!

Renew soon so that your kids can still visit the doctor or dentist whenever they need to.

If your kids don't have health insurance, go to www.arkidsfirst.com to see if they are eligible.

ARKids 1st
Healthy Kids. Healthy Families.
www.ARKidsFirst.com



Kindergarten Readiness Indicator Checklist for Parents

Arkansas's Definition of School Readiness: School ready children have the social and academic knowledge, skills and behaviors for school success and lifelong learning. School readiness occurs when families, schools and communities support and serve ALL children, so they are successful in school and in life.

This list of indicators identifies skills, knowledge and behaviors that will help your child be prepared for that special day, going to kindergarten. The checklist is NOT a test. It is a tool that you can use to help your child make the transition to kindergarten.

The Kindergarten Readiness Indicator Checklist

Social & Emotional Development

- ☐ Separates from caregiver to another trusted adult
- ☐ Shares, takes turns and plays cooperatively with other children
- ☐ Expresses basic emotions such as happy, sad, mad, or scared
- ☐ Responds sympathetically to others' distress with words and actions
- ☐ Recognizes similarities and differences in self and others (for example, boy or girl, hair and skin color)

Cognitive Development

- ☐ Is curious, interested and willing to try new things
- ☐ Completes a task such as working a puzzle
- ☐ Adapts to new situations
- ☐ Focuses and pays attention during an activity such as, during story time
- ☐ Engages in memory games such as, "What's Missing" and simple memory matching card games
- ☐ Uses number and letter like forms and/or drawings to represent ideas or feelings

Physical Development & Health

- ☐ Gallops, slides, hops, leaps and skips
- ☐ Steers a tricycle, balances on beam or sand-box edge
- ☐ Catches ball with both hands
- ☐ Tosses or throws balls
- ☐ Kicks moving ball while running
- ☐ Pours liquids without spilling and builds with Legos® or blocks
- ☐ Uses a 3-point finger grip on pencil, crayon or paint brush
- ☐ Makes a variety of lines and shapes such as O, __, +, □ and △
- ☐ Uses scissors correctly to cut simple shapes and pictures
- ☐ Buttons, zips, laces and buckles
- ☐ Names a variety of foods and begins to classify food items as either fruits or vegetables
- ☐ Is aware of safe behavior and follows basic safety rules and routines
- ☐ Takes responsibility for personal self-care routines such as handwashing, brushing teeth, dressing and toileting
- ☐ Can express own health needs such as, "I'm hungry", "My head hurts", "I'm tired."

Language Development

- ☐ Understands an increasing number and variety of words for objects, for actions, and to describe things
- ☐ Comprehends who, what, why and where questions
- ☐ Performs up to three-step directions
- ☐ Uses four to six word sentences
- ☐ Tells increasingly detailed stories or ideas
- ☐ Communicates clearly enough to be understood by most people
- ☐ Takes turns in conversation with others
- ☐ Responds to the English language
- ☐ Speaks and expresses self in English

Emergent Literacy

- ☐ Listens, tells and engages in story being read
- ☐ Participates in singing songs and saying rhymes
- ☐ Retells stories from favorite books and personal experiences
- ☐ Decides if two words rhyme for example, cat and bat
- ☐ Holds books right-side up, turns pages one at a time from front-to-back
- ☐ Recognizes print they see in their everyday life (for example, stop-signs and logos for Wal-Mart and McDonald's)
- ☐ Recognizes and names some letters of the alphabet, especially in their own name
- ☐ Produces the correct sounds for some of the letters of the alphabet
- ☐ Writes some letters correctly, especially those in own name

Mathematical Thinking

- ☐ Counts in sequence up to 20
- ☐ Understands and uses terms such as first, second and last
- ☐ Counts objects using one number for each object
- ☐ Recognizes four objects in a group without counting
- ☐ Recognizes numerals 1-10
- ☐ Sorts objects by color, shape and size
- ☐ Recognizes and repeats patterns such as triangle, square, triangle, square
- ☐ Measures and compares height of objects
- ☐ Arranges objects from shortest to longest, (for example, shoe sizes or different lengths of yarn)
- ☐ Recognizes and names familiar shapes such as square, triangle, circle, and rectangle
- ☐ Understands and uses words such as inside, outside, up, down, over and under

Science & Technology

- ☐ Asks questions about the world around them (for example, "What do plants need to grow?")
- ☐ Recognizes that living things change over time (for example, babies grow and become adults and seeds grow and become plants.)
- ☐ Recognizes and names these five colors: red, blue, yellow, green and black
- ☐ Uses simple technology devices such as touch screen, e-book reader or digital camera

Social Studies

- ☐ Knows own first and last name, age, and knows names of family members
- ☐ Understands and talks about today, yesterday, tomorrow, after lunch, day and night
- ☐ Is aware of familiar buildings and special places in the community such as, home, school, grocery store, and park

Creativity & Aesthetics

- ☐ Enjoys singing and moving to the beat and speed of music
- ☐ Explores drawing with crayons and markers
- ☐ Enjoys pretend play (for example, rocking a baby doll, driving a truck or pretending to talk on a toy telephone)



Crying is a
normal part of infant
development.

Prevention of Shaken Baby Syndrome

What is Shaken Baby Syndrome (Abusive Head Trauma)?

Shaken Baby Syndrome (SBS) is a type of inflicted traumatic brain injury that happens when very young children are violently shaken. SBS is the most common form of child abuse seen in children under age 1, but may be seen in children up to 3 years.

SBS Risk Factors Include

Young parental age, financial stress, child prematurity or disability, unrealistic expectations, rigid attitudes about how babies should behave, lack of knowledge about child development, impulsive behaviors, depression, or negative childhood experiences (neglect or abuse).

How Does it Happen?

Shaken Baby Syndrome occurs when a parent or caregiver becomes overwhelmed or angry with a crying infant or toddler. They shake the very young child due to frustration or as a way to stop the crying.

Babies and toddlers have weak neck muscles. Shaking can cause the fragile brain of a very young child to bounce back and forth inside the skull.

Shaking causes bruising, swelling, bleeding, brain damage, or death.

Did You Know?

Child care providers often have additional risk factors such as lack of help or support, caring for multiple children at once, and other children's reactions to the crying—**know your own stress level!**

Long-term Consequences of Shaking a Baby/Toddler

- Physical disabilities
- Blindness
- Hearing impairment
- Speech disabilities
- Cerebral Palsy
- Seizures
- Behavior Disorders
- Cognitive impairment
- Death (immediate or may occur later)

**SBS IS
100% PREVENTABLE.**
It's the leading cause of
death and disability
in infants.

**30% OF
SBS VICTIMS DIE.**
Nearly all survivors will
require lifelong care
for disabilities.

**National Center on
Shaken Baby Syndrome**

Website:
www.dontshake.org



By law, you **must** report any
suspected signs of abuse. To
report suspected child abuse, call
1-800-362-2178

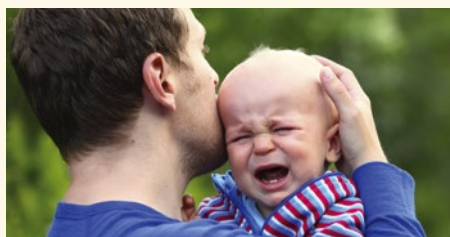
PERIOD OF PURPLE CRYING®

"The Period of PURPLE Crying®" is a recognized period of increased crying during normal development. The Period of Purple Crying® is an evidence-based approach to SBS prevention.

Purple Crying Website:
www.purplecrying.info

P.U.R.P.L.E					
P PEAK OF CRYING	U UNEXPECTED	R RESISTS SOOTHING	P PAIN-LIKE FACE	L LONG LASTING	E EVENING
Your baby may cry more each week. The most at 2 months, then less at 3 to 5 months.	Crying can come and go and you don't know why.	Your baby may not stop crying no matter what you try.	A crying baby may look like they are in pain, even when they are not.	Crying can last as much as 5 hours a day, or more.	Your baby may cry more in the late afternoon and evening.

WHEN A BABY/TODDLER WON'T STOP CRYING



Soothing Techniques

Make sure basic needs are met!

- Is the baby/toddler hungry?
- Is it nap time?
- Is the baby/toddler overstimulated?
- Is it time for a diaper change?
- Is the baby/toddler showing signs of illness?

Other Soothing Techniques

- Offer a pacifier (with parental permission).
- Change baby's position and perspective (*if baby is lying down, lift and carry or put in an infant seat, or try walking with baby*).
- Increase attention and close contact before the baby/toddler starts crying. This reduces crying overall.
- Babies respond well to rhythmic and repetitive sounds and patterns (*a lullaby, humming fan, or a "white noise" CD*).

Keep Crying Babies/Toddlers Safe

If you get frustrated and nothing you do is helping:

- Put the baby/toddler in a safe place (like a crib).
- Take a break.
- Take a few minutes to calm yourself down (*Take a deep breath. Count to 10 slowly*).
- Tend to other routines or children while keeping the baby/toddler in sight and hearing.
- Limit other children from the crying baby/toddler to prevent them from harming or agitating the baby/toddler further.

Make a Plan and Share with Families

A safe/supervised place I can leave the child for a short break is _____.

A calm and understanding person I can talk to is _____.

One thing I can do to calm myself down is _____.

If I need help caring for a child, I will _____.



Essentials Child Care Preservice Program is a multi-agency collaborative effort and is funded by Iowa Department of Human Services.

This institution is an equal opportunity provider. For the full non-discrimination statement or accommodation inquiries, go to www.extension.iastate.edu/diversity/ext. HS 771 | June 2021



We will host quarterly meetings (childcare provided) to discuss agenda items.

Parent/ Guardian Name(s): _____

Child(ren)’s Name(s): _____

Best Method of Contact: _____ **Email** _____ **Phone** _____ **Text**

Phone: _____ **Email:** _____

I am/ We are specifically interested in:

_____ **anything, I am happy to help with whatever!**

_____ **helping plan/ coordinate special school events**

_____ **helping plan/ coordinate classroom parties**

_____ **helping organize fundraisers**

_____ **other (please specify):** _____

_____ **I cannot commit to anything additional but would like to attend meetings and be involved in the happenings at LMLC.**



Procure Connect Daily Information

Little Martians Learning Center utilizes an application called Procure: Childcare App. This application is able to track daily information regarding your child's feedings, diapers, sleep, mood, activities, medicines, curriculum, photos, and much more! Parents can download the application in order to receive live updates regarding your child's activity throughout the day. Should you choose not to download Procure: Childcare app, an e-mail summarizing your child's day will be sent to you at the end of each day.

As we are setting up your child's account, parents will receive an invite directly from Procure via e-mail. Please ensure that we have the most up to date e-mail address for you on file. We are look forward to using this technology with our families so that there is a direct line of communication between teachers and parents throughout the day, as well as alleviate paper copy "my-day" sheets.

Parents can engage with their child's academics more easily, as well as invite other family members to engage or share your child's activities. With this application photos, milestones, and other helpful information will be at your fingertips.

If you would like more information regarding Procure: Childcare App, please visit schools.procureconnect.com

