

<b>Date Correction Plan Due</b> 12/21/2022	<b>NONCOMPLIANCE STATEMENT AND CORRECTION PLAN</b>	<b>TO FILE A COMPLAINT CALL</b> 262-446-7800
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**Use of Form:** This form is used by certification / licensing staff to identify statute and / or administrative rule violation(s) and to outline imposed plans of correction, if applicable. This form is used by certified operators / licensed centers to meet the requirements of DCF 202.065, DCF 250.04(2)(i) and (3)(d), DCF 251.04(2)(L) and (3)(f), DCF 252.41(1)(L) and (2)(k). Failure to submit an appropriate correction plan by the due date listed above may result in sanctions identified in the statute and / or administrative rule. Public Schools may submit plans of correction however are not required to do so.

**Instructions:** The Noncompliance Statement below identifies the violation(s) of child care statute and / or administrative rule identified by the certification / licensing specialist. Complete the section labeled "Correction Plan" by indicating the steps that will be taken to address and correct each of the listed noncompliance(s). Identify expected completion date(s) for each item. Return the original to your certification / licensing specialist for approval and retain a copy. If this is a licensed child care, post your copy of the noncompliance statement and correction plan near the license in accordance with Wis. Stat. 48.657. This request for a correction plan is not an order imposing a sanction or penalty pursuant to Wis. Stat. 48.715. If the department decides to apply a statutory sanction and / or penalty for facts arising from this finding or a future finding, you will be given a notice of the sanction and / or penalty and your appeal rights.

<b>Name - Certified Operator / Licensed Center</b> Ms Jane's House		<b>Provider Number / Facility ID Number</b> 6000571066 / 001 - 235391		
<b>Address - Facility (Street, City, State, Zip Code)</b> 3700 Willow Ct South Milwaukee WI 53172		<b>Telephone Number</b> 414-764-0424	<b>Date - Regulation Visit</b> 12/6/2022	
	<b>Rule/Statute Number Noncompliance Statement</b>	<b>Correction Plan</b>	<b>Expected Completion Date</b>	<b>Verification Date</b>
1	250.04(6)(a)1. <b>Child Record - Enrollment &amp; Health History Forms</b>  Description: Child 1 did not have an enrollment or health history form on file at the time of the visit.	Child Record - I had placed in another child's file by mistake. In future, I will try to be more careful!	12/8/22	
2	250.05(2)(c) <b>Staff File - Days, Hours Worked</b>  Description: Staff A and Staff B are not documenting their days and hours worked to meet staff to child ratio.	I had documented the hours in advance. In the future, I will write in hours, only on each day actually days worked	12/8/22	

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<b>NAME - Agency Worker</b> Sara Cooney	<b>Date Issued</b> 12/7/2022
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<b>SIGNATURE - Certified Operator or Designee / Licensee or Designee</b> 	<b>Date Signed</b> 12/8/22
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Use of form: Licensed Family Child Care Centers are required to complete Section A and Section B in order to comply with DCF 201.04(5)(b); Section C may be completed to ensure compliance with DCF 201.04(5)(c). Failure to comply may result in issuance of a noncompliance statement. This form may be used by Group Child Care Centers to ensure compliance with DCF 201.04(5)(b) and 201.05(2)(a)6, by Day Camps for Children to ensure compliance with DCF 202.41(4)(c) and 202.42(1)(a)6, and by certified providers to ensure compliance with DCF 202.03(5)(f) and 202.03(5)(g). Personal information you provide may be used for secondary purposes [Privacy Law, s. 19.04(1)(a), Wisconsin Statutes]. Completion of this form may also help ensure compliance with the Child and Adult Care Food Program regulation 7 CFR 226.18(e) and child care subsidy rules under DCF 201.04(5).

Instructions: The daily attendance record must be kept on file for the length of time the child is enrolled in the center for licensed centers and for at least 3 years for certified providers. Attendance records shall include all children in care, including the operator's / provider's own children under age 7. It is a requirement under Wis. Stat., 49.156(8m)(b) to retain attendance records for at least 3 years after the child's last day of attendance.

**SECTION A - Facility and Timeframe:**

Name - Facility MS. JANE'S HOUSE Facility ID Number 235391 Week of (mm/dd/yyyy) through (mm/dd/yyyy) 12-5-22 - 12-9-22

**SECTION B - Daily Attendance Record:** Enter the child's full name and date of birth for each child in attendance during the week. In the rows corresponding to the child's name, record the actual time the child arrives and the actual time the child departs, using a.m. / p.m. designations (do not record this information in advance). Times must be recorded immediately upon the child's arrival and departure, and the record must reflect all children in care at any given time. It is recommended that providers have the parents review this form for accuracy at the end of the week and sign the form as verification that it is correct.

Name - Child (First and Last)	Date of Birth	Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Parent Sign Off (signature)
		In	Out	In	Out	In	Out	In	Out	In	Out	In	Out			
1. MOM 414-762-2067 414-929-9246 CHRIS GIBSON	6-28-19			8:45	4:15											
2. MOM 206-532-5898 Jelie 608-769-3988 SONIA KAHWITZ	10-29-18			8:30	4:30	8:15										
3. #9 MOM - 414-768-4953 DAD - 926-918-6288 JEDNA DANKO-MEYER	8-26-19			7:30	5:15											
4. #10 GARRETT DANKO-MEYER	8-26-19			7:30	5:15											
5. #16 JORDY GIBSON	2-8-16			8:45	4:15											
6. MOM 414-573-7729 MELODY VEGA AUKS	1-20-12															
7. WAILAH VEGA AUKS	9-14-13															
8. #11 CARLY DANKO-MEYER	3-11-18															
9. #12 LILAH DANKO-MEYER	9-8-76															

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name, record the actual time the child arrives and the actual time the child departs, using a.m. / p.m. designations (do not record this information as arrivals). Times must be recorded immediately upon the child's arrival and departure, and the record must reflect all children in care at any given time. It is recommended that providers have the parents review this form for accuracy at the end of the week and sign the form as verification that it is correct.

Name - Child (First and Last)	Date of Birth	Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Parent Sign Off (Signature)
		In	Out	In	Out	In	Out	In	Out	In	Out	In	Out	In	Out	
10.																
11.																
12.																
13.																
14.																
15.																
Total Daily Attendance																

**SECTION C - Provider Schedule:** Enter full name and position title for each provider, additional provider, substitute or emergency backup provider who worked with the children during the week. In the rows corresponding to the provider's name, record the actual times the provider, additional provider, substitute, or emergency backup provider was counted in staff-to-child ratios, using a.m. / p.m. designations.

Provider Name and Position Title	Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	
	In	Out	In	Out	In	Out	In	Out	In	Out	In	Out	In	Out
Provider A: OWNER - MAIN Provider JANE ISAACS														
Provider B: Age To Ratio David ISAACS														
Provider C:														
Provider D:														

*J. J.*  


CHILD CARE ENROLLMENT

Use of form: Use of this form is mandatory for Family Child Care Centers to comply with DCF 250.04(6)(a)1. Failure to comply may result in issuance of a noncompliance statement. This form may also be used by Group Child Care Centers and Day Camps to comply with DCF 251.04(6)(a)1. and DCF 252.41(4)(a)1. respectively. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].  
Instructions: The parent / guardian shall fill out the form completely, sign it and submit it to the center prior to the child's first day of attendance. Information on this form shall be kept current. When enrolling a child under two years of age, a completed Intake for Child Under 2 Years form must also be on file prior to the child's first day of attendance.

<b>CHILD INFORMATION</b>		Birthdate (mm/dd/yyyy)	First Day of Attendance
Name (Last, First, MI) Gibson, Christian, A.		06/28/2019	09/01/2024

**PARENT OR GUARDIAN** - All parents / guardians are permitted to visit during center hours and are allowed to pick up the child unless access is prohibited or restricted by a court order. Attach court order, if any. If the child resides at multiple locations, the department recommends the provider obtain and attach a schedule.

a. Name and Relationship to Child Valerie Gibson - Mother	Home / Cell Phone No. (414) 762-2067	Email Address Where Reachable While Child is in Care vgibson@yaho.com
Home Address (Street, City, State, Zip) 521 South Milwaukee, WI 53172	Does child reside at this location? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Place of Employment and Work Phone No. GE Healthcare
b. Name and Relationship to Child - N/A -	Home / Cell Phone No. - N/A -	Email Address Where Reachable While Child is in Care - N/A -
Home Address (Street, City, State, Zip) - N/A -	Does child reside at this location? <input type="checkbox"/> Yes <input type="checkbox"/> No	Place of Employment and Work Phone No. - N/A -

**AUTHORIZED PERSONS** - Persons other than parents / guardians who are authorized to pick up the child or accept the child if dropped off. If no one, write "None."

a. Name and Relationship to Child Sonja Gibson - Maternal Grandma	Home / Cell Phone No. (414) 672-3931	Email Address Where Reachable While Child is in Care - N/A -	Place of Employment and Work Phone No. Retired
b. Name and Relationship to Child Kevin Gibson - Uncle	Home / Cell Phone No. (414) 841-1842	Email Address Where Reachable While Child is in Care kevgibson6@gmail.com	Place of Employment and Work Phone No. - N/A -

**EMERGENCY CONTACT** - The person to be notified in an emergency when parent's / guardians cannot be reached.

<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No This person is authorized to pick up the child.	Name and Relationship to Child Sonja Gibson - Grandma	Home / Cell Phone No. (414) 672-3931	Email Address Where Reachable While Child is in Care - N/A -	Place of Employment and Work Phone No. Retired
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<b>PHYSICIAN OR MEDICAL FACILITY</b>		Address (Street, City, State, Zip Code)	Telephone Number
Name Dr. Jeffrey Gell		1155 N. Mayfair Rd. Wauwatosa, WI 53226	(414) 955-5990

**AUTHORIZATIONS**

Yes  No I hereby give my consent for emergency medical care or treatment to be used only if I cannot be reached immediately.

Yes  No I have had an opportunity to review the policies of this child care center and a summary of the Wisconsin Rules for Licensing Child Care Centers.

Yes  No I give permission for my child to participate in  Transported  Walking field trips and other activities during operating hours.

Yes  No I have been informed of the number of pets in the center and their degree of contact with the enrolled children. Note: If pets are added after a child is enrolled, parents shall be notified in writing prior to the pet's addition to the center.

<b>SIGNATURE</b> - Parent or Guardian Valerie Gibson	Date Signed 09/01/2024
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## HEALTH HISTORY AND EMERGENCY CARE PLAN

**Use of form:** This form is required for family and group child care centers and day camps to comply with DCF 250.04(5)(a)1. and 250.07(6)(L)5., DCF 251.04(6)(a)3. and 251.07 and DCF 252.44(6)(j) of the Wisconsin Administrative Codes. Failure to comply may result in issuance of a non-compliance statement. Personal information you provide may be secondary purposes [Privacy Law, s.15.01(1)(m), Wisconsin Statutes].

**Instructions:** The parent / guardian should complete this form for placement in the child's file prior to the child's first day of attendance. Information contained on the form shall with any person caring for the child. The department recommends that parents / guardians and center staff periodically review and update the information provided on this form.

### CHILD INFORMATION

Name, (Last, First, MI) <i>Gibson, Christian, A.</i>	Address - Home (Street, City, State, Zip Code) <i>521 Southshore Place N202</i>	
Telephone Number <i>(414) 762-2067</i>	Birthdate (mm/dd/yyyy) <i>06/28/2019</i>	Date - First Day of Attendance (mm/dd/yy) <i>09/01/2021</i>

### PARENT / GUARDIAN INFORMATION Provide information where the parent(s) / guardian(s) may be reached while the child is in care.

Name <i>Sonja Gibson</i>	Telephone Number - Home <i>(414) 672-3931</i>	Telephone Number - Work <i>-N/A-</i>	Telephone Number - C <i>-N/A-</i>
Name <i>-N/A-</i>	Telephone Number - Home <i>-N/A-</i>	Telephone Number - Work <i>-N/A-</i>	Telephone Number - C <i>-N/A-</i>

### PHYSICIAN / MEDICAL FACILITY INFORMATION

Name - Physician <i>Dr. Jeffrey Gehl</i>	Address - Medical Facility <i>1155 N. Montrose R. Wausau, WI 53226</i>	Telephone Number <i>414-955-5</i>
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**SUNSCREEN / INSECT REPELLENT AUTHORIZATION** If provided by the parent, the sunscreen or insect repellent shall be labeled with the child's name. Per DCF 251.07(e) authorizations shall be reviewed every 6 months and updated as necessary. Per DCF 250.07(3)(f)2.a., Authorizations shall be reviewed periodically and updated as necessary.

<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to apply sunscreen to my child.	Brand Name <i>- Any -</i>	Ingredient (Strength) <i>SOT</i>
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to allow my child to self-apply sunscreen.		
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to apply repellent to my child.	Brand Name <i>- Any -</i>	Ingredient (Strength)
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to allow my child to self-apply repellent.		

### HEALTH HISTORY AND EMERGENCY CARE PLAN If available, attach any health care plan information from the child's physician, therapist, etc.

1. Check any special medical condition that your child may have.
- |  |  |  |  |
|--|--|--|--|
| <input checked="" type="checkbox"/> No specific medical condition              | <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Gastrointestinal or feeding concerns including special diet and supplements |
| <input type="checkbox"/> Cerebral palsy / motor disorder                       | <input type="checkbox"/> Epilepsy / seizure disorder | <input type="checkbox"/> Any disorder including Cognitively Disabled, LD, ADD, ADHD, or Autism |  |
| <input type="checkbox"/> Other condition(s) requiring special care -- Specify. |  |  |  |
- Milk allergy. If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative.
- Food allergies -- Specify food(s).
- Non-food allergies -- Specify.

2. Triggers that may cause problems -- Specify.

Strawberries, milk, peanut butter affect his skin lately. Dr. Stater is  
fixes to keep eating it though for exposure.

3. Signs or symptoms to watch for -- Specify.

Hives, Eczema and Psoriasis.

4. Steps the child care provider should follow. If prescription or non-prescription medications are necessary, a copy of the form *Authorization to Act*  
attached to this form. Note: Group child care centers and day camps may use their own form.

• Use given lotion for skin as needed.

5. Identify any child care staff to whom you have given specialized training / instructions to help treat symptoms.

a. Ms. Jane Zssek

b. Ms. Jane's son David

c.

6. When to call parents regarding symptoms or failure to respond to treatment.

For extremely emergencies.

7. When to consider that the condition requires emergency medical care or re-assessment.

If all is called, please use better judgement.

8. Additional information that may be helpful to the child care provider.

- N/A -

SIGNATURE -- Parent or Guardian

*John Quinn*

09/01/2021

Revision date: