The Wallingford Community Day Care Center, Inc.

Application/Change of Information

Name of Child__________________________ Enrollment Date______________________

Birth Date______________ SSN______-______-______ Gender________________

Address ______________________ City______________ State_____ Zip ________

Enrolling Parent/Guardian Name ___________________ Date of Birth ____________

Address ______________________ City______________ State_____ Zip ________

Phone_______________ Cell_______________ Email________________________

Place of Employment_____________________________ Work Phone________________

Work Hours____

Work Address____

Non-Custodial Parent/Other Parent Name_____________________________________

Address ______________________ City______________ State_____ Zip ________

Phone_______________ Cell_______________ Email________________________

Place of Employment_____________________________ Work Phone________________

Work Hours____

Work Address____

( ) joint custody; ( ) visitation rights; ( ) informal agreement;

Sees Child: ( ) often –weekly or more frequently; ( ) seldom –monthly or less; ( ) never;

Restraining Order? ( ) yes date_______________ ; ( ) no

Type of Family: ( ) 2 biological parents; ( ) single parent; ( ) step parent; ( ) grandparent; ( ) foster parent;

( ) other____

I confirm that I am the legal custodian of the enrolled child and that all the information given on this and other forms relative to enrollment of my child is true and accurate to the best of my knowledge and belief. I agree to abide by all the rules and regulations of this child care facility and to pay established weekly fees on Monday of the week of service.

Signature____ Date____________________

Confidential Financial Statement

Must be accompanied by 4 current pay stubs. All information **must** be completed.

IRS form#1040 required

Child's Name____ SSN________-________-________

Address ______________________________ City__________________ State______ Zip___________

Parent/Guardian Name_____________________________________ SSN________-________-________

Place of Employment ____ Gross Income $__________

2nd Parent/Guardian (if sharing household) Name ____

SSN ________-_________-________ Gross Income $_______________________________________

Place of Employment____

Other Family Income: Please Specify Amount Actually Received

Child Support $_______ month; AFDC $_______ month; Unemployment $______ month; Other $______ month

Type of Family: ( ) 1 parent; ( ) 2 parent; ( ) Other____

List all Family Members not reported above:

Name___________________ Age_______ SSN_______-_______-_______ Employed_________________

Name___________________ Age_______ SSN_______-_______-_______ Employed_________________

Name___________________ Age_______ SSN_______-_______-_______ Employed_________________

Total # of Children in Family__________________ Total # of Adults in Family______________________

State Assistance with Day Care ____________ If Yes, Program__________________________________

Client # ______________________ Name of Worker____

OFFICE USE ONLY

Date______________________ Family Size_________________________________

Family Total Income $____________________________ Fee $___________________

Required Documentation for Enrollment

$25.00 Application Fee

Child's Name____

Parent/Guardian Name____

Email Address____

Child's Social Security #__________-__________-__________ Date received/documented__________________________

Child's Birth Certificate ______________________________ Date received/documented__________________________

Proof of residency:

- Utility Bill: ( ) phone; ( ) cable; ( ) electric; ( ) gas
- Property Tax Bill: ( ) car; ( ) home
- Drivers License: ( ) only if none of the above can be provided [must match the address on the enrollment forms and the parent's pay stubs]
- State ID for non-driver: ( ) [may not be driving car to drop off or pick up children. address must match pay stubs and enrollment forms]

The information provided is true and correct to the best of my knowledge and belief. I understand that the child's enrollment may be terminated immediately if I fail to notify the office within 24 hours of ANY CHANGE in my or my child's residency, employment, custody of the child, or anything that may affect my child's eligibility for enrollment.

Signature ____Date______________________________

List Family Members Living in the Household, their Ages and Relationship to the Child:

___

___

___

___

___

Other Agencies/Child Care Family Has Used:

___

___

___

Languages Spoken in the Home:

___

FOR OFFICE USE ONLY:

Date submitted___ Date of visit___ Approved by___

Arrival time___ Departure time___ Starting date___ Last Physical___

( ) birth certificate; ( ) medical/insurance card; ( ) income verification

Dates of redetermination___

Dates contact/authorization info updated ___

Hours for care: M___ T___ W___ Th___ F___

Extra hours needed on days the public schools are closed: ( ) yes; ( ) no; ( ) sometimes

Date provider agreement sent to DSS___

Authorization for Child to be Picked Up at Child Care

Date_______________________

Name of Child____

I, *parent/guardian's name*____

Authorize those individuals (over 15 years of age) listed below to pick up and remove my child/children from the center and to provide transportation for my child/children.

Signature_______________________________ Date_______________________

PLEASE NOTE: Photo identification is required of all persons authorized to remove children from the center.

Name_______________________________ Relationship to Child_______________

Home Address ____

Home Phone/Cell Phone_______________________ Work Phone_______________________

Place of Employment____

Name_______________________________ Relationship to Child_______________

Home Address ____

Home Phone/Cell Phone_______________________ Work Phone_______________________

Place of Employment____

Name_______________________________ Relationship to Child_______________

Home Address ____

Home Phone/Cell Phone_______________________ Work Phone_______________________

Place of Employment____

Absent Parent's Consent for Emergency Treatment of Minors

In the event of a medical emergency, center staff will call 911. Transportation will be provided by emergency services to an appropriate medical facility as is determined by the emergency response unit.

I **give my permission** for *Child's Name*____ to receive emergency medical treatment and transportation to an appropriate medical facility for any additional treatment as may be indicated.

I **authorize** any licensed physician to provide treatment, order injections, hospitalize, give anesthesia or perform surgery for *Child's Name*______________________________________ during my absence.

I **understand** that this authorization is given prior to any need for medical treatment, but is given to avoid unnecessary delay in emergency treatment, which the physician may deem advisable in the exercise of his/her best judgment. I presume a reasonable attempt will be made to contact me.

Signature____ Date________________________

Relationship to Child____

In the event of such an emergency involving my child and I cannot be reached, The Wallingford Community Day Care Center, Inc. should contact the following:

Name__________________________ Phone: home______________ work________________

Relationship to Child____

Name__________________________ Phone: home______________ work________________

Relationship to Child____

Signature____ Date________________________

Name Printed____

Known Medical Problems____

Medications______________________________ Allergies____________________________

Date of Last Tetanus Shot_______ Child's Physician______________________ Phone__________

NON-MEDICAL EMERGENCY PHONE NUMBERS

In the event of a non-medical emergency, such as an early closing due to inclement weather, the individuals listed below may be called to pick up and remove my child from the center and provide transportation:

Signature____ Date______________________

Name______________________________ Relationship to Child ______________________

Home Address____

Home/cell phone_________________________ Work phone_________________________

Signature____ Date______________________

Name______________________________ Relationship to Child ______________________

Home Address____

Home/cell phone_________________________ Work phone_________________________

Signature____ Date______________________

Name______________________________ Relationship to Child ______________________

Home Address____

Home/cell phone_________________________ Work phone_________________________

Signature____ Date______________________

Name______________________________ Relationship to Child ______________________

Home Address____

Home/cell phone_________________________ Work phone_________________________

Other Permissions

I give my permission for *Child's Name*_______________________________________ to be given first aid should the need arise.

Signature____ Date_____________________________

Relationship to child ____

I give my permission for *Child's Name*____ to accompany the children of the Wallingford Community Day Care Center, Inc. on field trips made during the time of enrollment. I understand that transportation will be by vans or buses.

Signature____ Date_____________________________

Relationship to child ____

I give my permission for *Child's Name*____ to accompany the children of the Wallingford Community Day Care Center, Inc. on supervised walks off the center premises.

Signature____ Date_____________________________

Relationship to child ____

I give my permission for *Child's Name*____ to be photographed by center personnel, the newspaper and the media. I also allow them to use my child's name.

Signature____ Date_____________________________

Relationship to child ____

Parent/Guardian Agreement

Child's Name_______________________________________ Date of Birth______________________________

Is enrolled in the____ program.

I,____(please print parent name) agree to the following terms.

1. To abide by all of the rules and regulations established by the Board of Directors for the operation of the program.
2. To pay the weekly fee of $______________ on Monday of the week of service regardless of attendance or center closing due to weather emergency.
3. To notify the center when my child will not be in attendance.
4. To provide the center with valid phone numbers, employment information, and up to date emergency contact numbers.
5. To notify the center immediately when there is any change in my employment status, work hours or earned income.
6. To notify the center of any potential custodial disputes or other concerns which may prove distressing or harmful for my child or others in the program.

The hours and days for which care is needed are:

Monday_____________________ AM to__________________ PM

Tuesday ____________________ AM to__________________ PM

Wednesday _________________ AM to__________________ PM

Thursday____________________ AM to__________________ PM

Friday ______________________ AM to__________________ PM

Please note: State rules allow for 1/2 hour travel time to and from your place of employment.

I understand that service may be terminated immediately if any terms of this agreement are violated. This agreement is valid for one year from date of signature unless revised or terminated.

Signature ____Date____________________________

Pre-Admission Record

Child's Full Name________________________ Birthdate____________________

Child's Nickname____________________ Place of Birth ____________________

Brothers & Sisters - Names & Ages:____

____

Parents Names____

Eating:

Is child able to feed himself? __________ Slow__________ Fast __________ Utensil________

Appetite ___________ Child Likes__________________ Child Dislikes________________

Allergies____

Sleeping:

Usual bed time________________________ Gets up______________________

Sleeps through night?____________________ Bed wetting?____________________

Nap? ________ How long? _________ Does child share room? _______With whom? _______

Bed____________ Crib ____________ Other (specify)_____________________

Toilet Habits:

Does child tell adult when he/she needs to go to the toilet?__________________________

Terms used – Bladder__________________ Bowels_________________________

Can he/she manage on their own completely? __________________________________

Dressing:

Can child dress himself/herself? _________________ Undress? ___________________

In what areas does he/she need help?____

Buttons? ______________ Zippers? _______________ Tie Laces?_______________

Development:

Speech _______________________ Clear ___________________________________

Fears or Habits ____

Thumb Sucking ________ Nail Biting________ Strong Temper________ Self-Reliant________

Comments____

80 Wharton Brook Dr. Wallingford, CT 06492 | 203-294-4176 | www.wallingfordcommunitydaycare.com

Right Handed ______________ Left Handed ______________ Glasses ______________

Physical Abnormalities____

Play and Relationship with Others:

Chief play interests____

Favorite Toys ____

Facilities in Home______________________ In Yard/etc______________________

Plays alone__________ With others__________ Age range__________ Adults__________

Can he share? (if playing with others) ____

Other group experiences____

____

Reaction to strangers____

Additional information____

____

____

Signature ______________________________Date______________________

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Parent/ Guardian Authorization
for the Administration of Non-Prescription Topical Medications by Day Care Personnel

To Day Care nurse, director or teacher:

I hereby request that a staff member of the day care facility administer the following non-prescription topical medications to my child. I understand that I must supply the child day care center or group day care home with the non-prescription topical medication in the original container labeled with the child's name, the name of the medication and the directions for the medication administration.

This authorization is limited to the following topical medications:

1. Non-prescription diaper changing ointments that are free of antibiotics, antifungal or steroidal components
2. Non-prescription medicated powders
3. Non-prescription teething medications
4. Non-prescription insect repellents*
5. Non-prescription sunscreen protectants* that are free of amino benzoic acid (PABA) or its derivatives*

Name of Child_______________________________ Date of Birth____________________

Address____

Medication Name, method of administration, area of application______________________

____

Schedule of administration____

Medication shall be administered from (date) ________________ to (date) __________________

Reason for which medication is being administered______________________________

I have administered at least one dose of the above medication to my child without adverse side effects.

Print Name of Parent/Guardian____________________________ Date__________________

Signature __________________________________ Relationship to child________________

Address ____ Phone__________________

<u>FOR STAFF TO COMPLETE</u>

Parent Authorization Form and medication received by (staff signature) ______________________

Medication started (date and time)____

Medication ended (date and time)____

State of Connecticut Early Childhood Health Assessment Record

To Parent or Guardian:

In order to provide the best experience, early childhood providers must understand your child's health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he or she completes the health evaluation (Part II). State law requires complete primary immunization and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse, a physician assistant or the school medical advisor prior to entering an early childhood program in Connecticut.

Name of child______________________________ SSN____________________ Date of Birth______________ Sex__________

Address____

Parent/Guardian________________________________ Phone______________________ Work Phone__________________

Ethnicity (american indian, asian, black, white, hispanic, other)____

Early childhood program ____Program Phone______________________

Primary health care provider_________________________________ Preferred hospital____________________________

Health insurance company/number* or Medicaid/number*____

* If applicable If your child does not have health insurance, call 1-877-CT-HUSKY

Part I — To be completed by parent

Important: Complete Part I before your child is examined. Take this form with you to the health care provider's office. Please check answers to the following questions in columns on the left. (Explain all "yes" answers in the space provided below.)

Yes No

1. ❑❑Do you have any concerns about your child's general health, development or behavior?
2. ❑❑Has your child been diagnosed with any chronic disease ❑asthma ❑diabetes ❑seizure disorder ❑other
3. ❑❑Does your child have any allergies (food, insects, medication, latex, etc.) Please specify________________________

____

4. ❑❑Does your child take any medications (daily or occasionally)?
5. ❑❑Does your child have any problems with vision, hearing or speech (glasses, contacts, ear tubes, hearing aids)?
6. ❑❑Has your child had any hospitalization, operation, major illness or injury, or significant accident?
7. ❑❑In the last 12 months, has your child experienced any difficulty with wheezing or excessive night coughing?

8. ❑❑In the last 12 months, has your child experienced any difficulty with excessive weight loss or weight gain, or excessive thirst or urination?
9. ❑❑Has your child had a dental examination in the last 12 months?
10. ❑❑Would you like to discuss anything about your child's health with the child care provider or health consultant/coordinator? Please explain any "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

____

____

I give permission for release of information on this form for confidential use in meeting my child's health and educational needs in the early childhood program.

Signature of Parent/Guardian______________________________ Date__________________

ED191 REV. 8/2004 C.G.S. Section 10-16q, 10-206, 19a-79(a), 19a-87b(c);
P.H. Code Section 19a-79-5a(a)(2), 19a-87b-10b(2)

Part II — Health Evaluation

To the Health Care Provider: Please complete all sections and sign. Explain any screenings required by age but not conducted.

Child's Name______________________________ Birth Date (mm/dd/yy)__________________

Date of History/Physical Exam (mm/dd/yy)______________________________

LENGTH/HEIGHT	WEIGHT	WT FOR HT/BMI	HEAD CIRCUMF.
IN/CM %ILE	LB/KG %ILE	%ILE	IN/

Screening/Test Results

Screening Test			
Vision[2] Test type:			
Hearing[3] Test type:			
Lead[4] Risk: Yes/No			
TB[4] Risk: Yes/No			
Urinalysis (UA)[4]			
Anemia[5] (HGB/HCT) Risk: Yes/No			
Developmental Assessment[6] Test type:			

Immunization Record

Vaccine (Month/Day/Year)	Dose 1	Dose 2	Dos
DTP			
DTP/Hib			
DTaP DT/Td			
OPV			
IPV			
MMR			
Measles			
Mumps Rubella			
HIB			
Hep B			
Varicella			
PCV			

Other Vaccines (Specify)

Disease Hx of above (Specify) (Date mm/
Temporary _____ **Date** _____ Recertify Da

❑ exercise induced ❑ unclassified * **Chronic Disease Assessment:** ❑ ❑ Asthma: ❑ mild ❑ moderate ❑ severe ❑ ❑ Diabetes: ❑ Type I ❑ Type II ❑ ❑ Anaphylaxis: ❑ med. ❑ food ❑ insect ❑ latex ❑ ❑ Seizures: Type Yes No Date of onset ❑ ❑ Other: Please specify **Has this child received dental care in the last 12 months?**[7] ❑ **Yes** ❑ **No** ❑ **N/A** **Minimum requirements:** [1]**Up to 2 years;** [2]**annual at 3 years;** [3]**annual at 4 years;** [4]**as needed;** [5]**9–12 months;** [6]**each visit through 5 years;** [7]**annual at 2–3 years. Federal requirements (eg, Head Start, WIC) may vary. *Prior to Public School Entry: Same as above and Hgb/hct.**

This child has the following problems, which may adversely affect his or her educational experience:

❑ Vision ❑ Auditory ❑ Speech/Language ❑ Physical Dysfunction ❑ Emotional/Social ❑ Behavior

❑ The child has a health condition which may require intervention at the program, e.g., seizures, allergies, asthma, anaphylaxis, special diet, long-term medication. (specify) ____

____

____

❑ Yes ❑ No This child has a medical or emotional illness/disorder that now poses a risk to other children or affects the child's ability to participate safely in the program.

❑ Yes ❑ No Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.

❑ The child may fully participate in the program.

❑ The child may fully participate in the program with the following restrictions/adaptation: (specify reason and restriction.) ____

____

❑ I would like to discuss information in this report with the early childhood provider and/or health consultant/coordinator.

Signature of health care provider (MD,DO,NP, PA)____

Print Name____ Phone____________________________________

Address____

❑ Yes ❑ No Is this the child's medical home?

Next appointment (mm/yy)_______________ Next immunization appointment (mm/yy)____________________