BOYS & GIRLS CLUB
OF NORTHERN WESTCHESTER

REGISTRATION

Early Childhood Education 2019-2020

SEPTEMBER 3rd, 2019 - AUGUST 22nd, 2020

OFFICE USE ONLY

REGISTRATION FEE : _____ RECEIPT# _____

PROGRAM FEE: _____ DATE _____

CHECK: _____ CASH ( ) CC( ) TAKEN BY _____

This day care facility participated in the child and adult care food program CACFP,

A federal program that provides healthy meals and snacks to children receiving day care

Todays Date: _____

_____ 49 Week Program 7:30 am - 6:30 pm (Child must be 3 Years Old by December 1st 2019 and Fully Toilet Trained)

_____ 41 Week Program (Child must be 3 Years Old by December 1st 2019 and Fully Toilet Trained)

_____ 7 Week Summer Only Program (Child must be 3 Years Old by December 1dt 2019 and Fully Toilet Trained)

_____ Deposit of $75 per child

Parents Full Name _____ Home _____

Address _____ Cell _____

Email Address _____ Work _____

1. CHILD INFORMATION

Childs Full Name _____ Male ( ) Female ( ) DOB: _____

ECE Registration 5 Days _____ 4 Days _____ 3 Days _____ Hours Needed _____

MON ( ) TU ( ) WED ( ) TH ( ) FR ( )

2. CHILD INFORMATION

Childs Full Name _____ Male ( ) Female ( ) DOB: _____

ECE Registration 5 Days _____ 4 Days _____ 3 Days _____ Hours Needed _____

MON ( ) TU ( ) WED ( ) TH ( ) FR ( )

Information Strictly Confidential

Number in Household _____ Single Parent : YES ( ) NO ( )

Ethnic Background:

White _____ Black/African American _____ Hispanic/Latino _____

Native Hawaiian or Pacific Islander _____ American Indian or Native Asian _____ Other _____

Household Income

( ) < 24,000 ( ) $25,000 - $50,000 ( ) $50,000 - $80,000 ( ) $81,000 and Above

BOYS & GIRLS CLUB
OF NORTHERN WESTCHESTER

PRE SCHOOL INTAKE FORM

Childs Full Name _____ M _____ F _____ D/O/B _____
Childs Full Name _____ M _____ F _____ D/O/B _____

PARENT OR GUARDIAN INFORMATION

Parent Name _____ Home Phone # _____
Parent Address _____
Occupation or Place of Employment _____
Cell Phone # _____ Work Phone # _____
Parent Name _____ Home Phone # _____
Parent Address (If Different From Above) _____
Occupation or Place of Employment _____
Cell Phone # _____ Work Phone # _____

FAMILY INFORMATION

Brothers and/or Sisters (Please Indicate Ages and Whether they Live with the Child) _____

Please List any Other Person Living with the Child and their Relationship (If Any) to the Child _____

PERSONAL HISTORY

Is the Child Right or Left Handed? R _____ L _____
Has the Child had Previous Group Experience? Yes _____ No _____
If Yes, Where and When? _____
What Words does your Child use for Toileting? _____
Does your Child have any Bowel or Bladder Irregularities? Yes _____ No _____
Does your Child have Tantrums? Yes _____ No _____
Does your Child Suck their Thumb? Yes _____ No _____
Does your Child have any Fears? Yes _____ No _____

Is there any Other area which you Anticipate Difficulty for your Child Such as Sharing, Crafts or Following Directions?

Yes _____ No _____
Is there any Other Information such as Discipline, Child's Communication, Comforting Etc. That You feel would be Helpful to Us? _____
List any Special Interests you Child has. _____
Are there any Special Food or Eating Instructions? _____
Are there any Special Sleeping or Napping Instructions? _____
What do You Expect your Child to get out of his/her Preschool Experience? _____

BOYS & GIRLS CLUB
OF NORTHERN WESTCHESTER

Preschool (2019 - 2020) _____
Classroom # _____
Summer Only _____

EARLY CHILDHOOD EDUCATION PERMISSIONS

Childs Last Name _____ First Name _____ Age in 2019 _____
Childs Last Name _____ First Name _____ Age in 2019 _____
Childs Last Name _____ First Name _____ Age in 2019 _____
Childs Last Name _____ First Name _____ Age in 2019 _____

PERMISSION TO SWIM

I give my Child/Children permission to participate in swimming as part of his/her Early Childhood Education Program at The Boys & Girls Club of Northern Westchester.

Date _____ Signature of Parent/Guardian _____

PHOTO & VIDEO RELEASE FORM

I , the undersigned, being the parent or legal guardian of child/children, do hereby authorize The Boys & Girls Club of Northern Westchester to use PHOTOGRAPHS OR VIDEO RECORDING of my child for the purpose of PUBLIC RELATIONS, TRAINING AND/OR MONITORING STAFF without time limitations. I understand that I will be notified of such video taping of photography.

Date _____ Signature of Parent/Guardian _____

CAR POOL PERMISSION SLIP

I give Permission for the Following People to Pick Up My Child/Children

Name _____ Phone _____
Name _____ Phone _____
Name _____ Phone _____
Name _____ Phone _____

Date _____ Signature of Parent/Guardian _____

Note: Individual Handwritten Permission Slips are Required for any Person Not on this List to be Able to Pick Up Your Child/Children for Play Dates Etc.

CREDIT CARD AUTHORIZATION FORM

PROGRAM NAME: _____

CHILD'S FULL NAME: _____

NAME: _____

BILLING ADDRESS:
(of Credit Card) _____

_____

Telephone #: _____

Email Address: _____

Name on Credit Card: _____

Credit Card Type: MC _____ VISA _____ Discover _____ AMEX _____

Credit Card #: _____ CCV _____

Expiration Date: _____

Total Due: _____

Date: _____

Boys & Girls Club of Northern Westchester is authorized to charge my credit card as follows:

( ) ONE TIME PAYMENT OF _____

( ) AUTOMATIC MONTHLY PAYMENTS OF _____

Authorized Signature: _____

OCFS-LDSS-0792 (10/2018) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

DAY CARE ENROLLMENT

PHOTO OF CHILD (Optional)	Child's Full Name: Preferred Name/Nickname:	Date of Birth: / /	Gender:
	Child's Home Address:		
	Name of Person Enrolling Child:	Relationship to Child: ☐ Parent ☐ Guardian ☐ Caretaker ☐ Relative ____ ☐ Other ____	
	Phone Number(s) of Person Enrolling Child: ( ) - ☐ ok to text **Email Address:**	Address of Person Enrolling Child (if different than child):	

EMERGENCY INFO	EMERGENCY CONTACT NAMES / ADDRESSES	Authorized to Pick Up	PRIMARY PHONE NUMBER	OTHER PHONE NUMBER / EMAIL
	Primary Contact:	☐ Yes ☐ No	☐ ok to text	☐ ok to text
		☐ Yes ☐ No	☐ ok to text	☐ ok to text
		☐ Yes ☐ No	☐ ok to text	☐ ok to text

For Program Use Only Date of Enrollment: / /	*For Program Use Only* Date of Disenrollment: / /

OCFS-LDSS-0792 (10/2018) REVERSE

EMERGENCY INFORMATION

Child's Full Name:	Date of Birth: / /

Check boxes below to indicate if your child has any special needs/services: ☐ None

☐ Early Intervention/Special Education ☐ Occupational Therapy ☐ Speech/Language ☐ Physical Therapy

☐ Allergies (list) _____

☐ Other _____ Health Care Insurance Carrier: _____

Please provide information here **AND** discuss with your child care provider:

Child's Primary Care Physician's Name/ Group:	Phone Number: ( ) -
Preferred Hospital:	Phone Number: ( ) -
Child's Dental Care:	Phone Number: ( ) -

Child health insurance information is available by calling toll-free 1-800-698-4543 or the NYS Health Marketplace website: https://nystateofhealth.ny.gov/

AGREEMENTS

- I consent to emergency medical treatment for my child..... ☐ Yes ☐ No
- I consent for my child to take part in neighborhood trips (i.e., library, park and playground) away from the program under proper supervision..... ☐ Yes ☐ No
- I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips..... ☐ Yes ☐ No
- I provided information on my child's special needs to the program to assist in caring for my child..... ☐ Yes ☐ No
- I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation..... ☐ Yes ☐ No
- I agree to review and update this information whenever a change occurs and at least once every year..... ☐ Yes ☐ No

SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE:	DATE: / /

NEW YORK STATE | Department of Health | Child and Adult Care Food Program

LETTER TO HOUSEHOLDS

Dear Parent, Guardian or CACFP Participant:

This center participates in the Child and Adult Care Food Program (CACFP). It serves healthy meals each day it is open. Please complete the attached form soon. This will help your center receive funding for the meals that are served.

You will need to complete a form every year. Your center and CACFP will keep all information private.

INCOME ELIGIBILITY GUIDELINES
(Effective July 1, 2018 until June 30, 2019)

HOUSEHOLD SIZE	REDUCED-PRICE MEALS		
	YEAR	MONTH	WEEK
1	22,459	1,872	432
2	30,451	2,538	586
3	38,443	3,204	740
4	46,435	3,870	893
5	54,427	4,536	1,047
6	62,419	5,202	1,201
7	70,411	5,868	1,355
8	78,403	6,534	1,508
FOR EACH ADDITIONAL FAMILY MEMBER	+7,992	+666	+154

SPONSOR/CENTER OFFICIAL _____ SPONSORING ORGANIZATION _____ DATE _____

This institution is an equal opportunity provider.

NEW YORK STATE DEPARTMENT OF HEALTH
Child and Adult Care Food Program

Income Eligibility Form
for Child Care Centers

See INSTRUCTIONS on reverse.

CHILD CARE CENTER NAME _____

Print the name of the child(ren) enrolled in this child care center

1. _____ 2. _____ 3. _____

DIRECTIONS

Complete SECTION A if anyone in your household
1. Participates in the Supplemental Nutrition Assistance Program (SNAP)
2. Receives Temporary Assistance to Needy Families (TANF)
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR) OR
4. Is a foster child

SECTION A

SNAP Case # _____

TANF # _____

FDPIR # _____

Names of Foster Children _____

_____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true. I understand that the center will get Federal funds based on the information I give.

Signature _____

Date _____

FOR SPONSOR USE ONLY

CACFP Agreement # _____

Total Number of Household Members _____ (INCLUDING FOSTER CHILDREN, IF APPLICABLE)

Total Household Income $ _____

Free _____ # Reduced _____ Paid _____

Date of Determination _____

Signature of Center Staff _____

Complete SECTION B if no one in your household participates in SNAP, receives TANF, participates in FDPIR or if none of the children enrolled in the child care center is a foster child.

SECTION B

List all household members below. Include yourself and all adults and children NOT listed above, even if they do not receive income. Then list all income received **last month** in your household in the column to the right. Gross income includes: earnings from work, pensions, retirement, Social Security, child support, foster child's personal income and any other sources of income.

HOUSEHOLD MEMBER NAME	MONTHLY GROSS SALARY
1. _____	$ _____
2. _____	$ _____
3. _____	$ _____
4. _____	$ _____
5. _____	$ _____
6. _____	$ _____
7. _____	$ _____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true and that all income is reported. I understand that the center will get Federal funds based on the information I give.

Signature _____

Print Name _____

LAST FOUR (4) DIGITS OF SOCIAL SECURITY NUMBER ☐☐☐☐ DATE _____

USDA is an equal opportunity provider and employer.

OCFS-LDSS-4433 (Rev. 5/2014) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD IN CARE MEDICAL STATEMENT

To Be Completed By Licensed Physician, Physician's Assistant or Nurse Practitioner

Name of Child:	Date of Birth:	Date of Examination:

Immunizations required for entry into day care ☐ Yes ☐ No

Medical Exemption The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s).

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1st Date	2nd Date	3rd Date	4th Date	5th Date
Polio (IPV or OPV)	1st Date	2nd Date	3rd Date	4th Date	
Haemophilus influenzae type B (Hib)	1st Date	2nd Date	3rd Date	4th Date OR 1st Date (if given on or after 15 months of age):	
Pneumococcal Conjugate (PCV) for those born on or after 1/1/08)	1st Date	2nd Date	3rd Date	4th Date	
Hepatitis B	1st Date	2nd Date	3rd Date		
Measles, Mumps and Rubella (MMR)	1st Date	2nd Date			
Varicella (also known as Chicken Pox)	1st Date	2nd Date			

Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:

Tests

Tuberculin Test Date: ___/___/___ Mantoux Results: ☐ Positive ☐ Negative _____ mm

TB Tests are at the physician's discretion. Acceptable tests include Mantoux or other federally approved test.

If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: ___/___/___

Attach lead level statement

Lead Screening (Include All Dates and Results)

1 year ___/___/___ Result: _____ mcg/dL ☐ Venous ☐ Capillary

2 years ___/___/___ Result: _____ mcg/dL ☐ Venous ☐ Capillary

Most recent date of lead screening (if different from above):

___/___/___ Result: _____ mcg/dL ☐ Venous ☐ Capillary

Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely. If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.

MUST USE THIS FORM

(SEE REVERSE)

(Continued on reverse side)