INTAKE FORMS CHECKLIST

Child's Name: _____ DOB: _____

A registration fee of $100 is required for enrollment. This is non-refundable.

Please return the following paperwork for enrollment:

- ☐ Emergency Numbers & Pick-up Authorization form
- ☐ Child Enrollment & Emergency Medical Care form
- ☐ Child/Family Personal History packet
- ☐ Early Childhood Health Assessment Record (child's physical)
- ☐ CACFP Income Eligibility Application (required for all children)
- ☐ CACFP Child Enrollment form (required for all children)
- ☐ Parent Directory form
- ☐ Permission to Photograph/Video form
- ☐ Permission for Sunscreen and Insect Repellent
- ☐ Parental Consent form
- ☐ Branford Early Learning Center Parent Agreement
- ☐ Permission for Topical Medication (if applicable; ex: rash creams, Aquaphor, etc.)
- ☐ Authorization for Medication Administration and Action Plan from Doctor (if applicable; ex: children with asthma that require an inhaler)
- ☐ Copy of Birth Certificate
- ☐ Copy of W2's, tax return or 4 weeks of paystubs for household members
- ☐ Copy of licenses from both parents/legal guardians

You will also receive:

BELC School Calendar

Parent Handbook

Welcome Letter which includes a list of things your child will need

EMERGENCY NUMBERS & PICK-UP AUTHORIZATION

BELC
BRANFORD EARLY LEARNING CENTER

Enrollment Date: _____

Child's Name: _____ DOB: _____

Address: _____

Home Phone Number: _____

Parent's Name: _____

Parent's Address (if different): _____

Parent's Place/Address of Employment:_____

Parent's Cell Phone #: _____ Main point of contact? **Y** **N**

Parent's Work #: _____ May we contact you at this #? **Y** **N**

Parent's email: _____

Parent's Name: _____

Parent's Address (if different): _____

Parent's Place/Address of Employment:_____

Parent's Cell Phone #: _____ Main point of contact? **Y** **N**

Parent's Work #: _____ May we contact you at this #? **Y** **N**

Parent's email: _____

Physician's Name: _____ Phone #: _____

Insurance Company: _____ Policy Number:_____

Dentist's Name: _____ Phone #: _____

In the event that the parent(s) are unable to pick up, the following are allowed to pick up child:

_____ Relationship: _____ Phone #: _____

_____ Relationship: _____ Phone #: _____

_____ Relationship: _____ Phone #: _____

_____ Relationship: _____ Phone #: _____

_____ Relationship: _____ Phone #: _____

In the event of an emergency, the following are allowed to be contacted if parent(s) are unavailable:

_____ Relationship: _____ Phone #: _____

_____ Relationship: _____ Phone #: _____

_____ Relationship: _____ Phone #: _____

YOUR CHILD WILL NOT BE RELEASED TO ANYONE NOT LISTED ON THIS FORM. SHOULD THERE BE A TIME WHERE SOMEONE WHO IS NOT ON THE LIST COMES TO PICK THEM UP, A WRITTEN CONFIRMATION FROM EITHER PARENT IS REQUIRED. THIS CAN BE DONE VIA BRIGHTWHEEL OR BY CALLING THE FRONT OFFICE (203-488-4512**) TO LET US KNOW. A PHOTO ID IS REQUIRED FOR ENTRY, FOR THOSE WHO ARE UNFAMILIAR TO STAFF. IF PARENTS ARE DIVORCED, SEPARATED, OR IN A SITUATION WHERE CHILD CUSTODY IS QUESTIONED, BRANFORD EARLY LEARNING CENTER, INC. MUST HAVE ALL COURT ORDERED DOCUMENTS IN REGARD TO CUSTODY AND/OR VISITATION, AND CARE OF CHILD(REN). PLEASE NOTE: A COPY OF THE COURT DECISION MUST BE ON-FILE IN ORDER FOR THE PROGRAM NOT TO RELEASE A CHILD TO HIS/HER NON-CUSTODIAL PARENT.**

Signature: _____ Date: _____

CHILD ENROLLMENT & EMERGENCY MEDICAL CARE

BELC
BRANFORD EARLY LEARNING CENTER

Enrollment Date: _____

Child's Name: _____ DOB: _____

Address: _____ City: _____ Zip Code: _____

Parent's Name: _____ Cell Phone #: _____

Parent's Address (if different): _____ City: _____ Zip Code: _____

Parent's Employer:_____ Work Phone #: _____

Employer Address: _____ City: _____ Zip Code: _____

Weekly Care Schedule:
(please include the child's hours that they are in care each day)

Sunday: _____

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Saturday: _____

Person permitted to remove the child from Branford Early Learning Center, Inc. on behalf of the parent:

_____

Phone #: _____ Relationship: _____

Person to be contacted in the event of an emergency and the parent(s) cannot be reached and to whom the child can be released:

_____

Phone #: _____ Relationship: _____

Medical Information

Known Allergies: _____

_____

Insurance Company: _____ Insurance ID: _____ Policy #: _____

Child's Physician: _____ Phone #: _____

Child's Dentist: _____ Phone #: _____

Emergency Authorization

I give my consent for the First Aid and CPR certified staff of Branford Early Learning Center, Inc., to administer first aid and CPR to my child and to contact the above named physician or dentist if my child has a medical emergency. I also give my consent for my child to be transported to the nearest hospital, Yale New Haven Hospital, in the event of a medical emergency. I am aware that I will be responsible for all medical fees.

Preferred Medical Facility, if not Yale: _____

Signature: _____ Date: _____

CHILD/FAMILY PERSONAL HISTORY

The purpose of securing the information in this packet is to help the child care staff better understand your child and how to help them grow in all aspects. Your child's care during the day is a responsibility we share. All information is kept confidential and requires your written permission, if it is to be shared. While some questions may not be applicable to your child at this time, all questions are important and provide us insight. Please fill out as much as possible and leave what is not applicable blank.

Personal History

Type of Birth: ☐ Full Term ☐ Premature Were there any complications? Y N

If yes, please explain: _____

_____

At what age did they begin:

Sitting? _____ Crawling? _____ Walking? _____ Talking? _____

Do they speak in words? Y N Sentences? Y N Are you concerned for their speech? Y N

If yes, please explain: _____

_____

Are they a good climber? Y N Do they fall easily? Y N

Are you concerned for their motor skills? Y N If yes, please explain: _____

Family, Social and Emotional History

Guardian #1 Name: _____ Age: _____

Guardian #2 Name: _____ Age: _____

Living Arrangement and Status of Parents/Guardians:

☐ Married ☐ Divorced ☐ Separated ☐ Single Parent

If divorced or separated, how long? _____

Are there any custody/visiting arrangements? _____

_____

Siblings? Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

How do they get along with their siblings? _____

_____

CHILD/FAMILY PERSONAL HISTORY

Family, Social and Emotional History Contin.

Any other members in household? Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

How long have you lived in your current home? _____

Do you speak any other languages at home other than English? _____

Are there any cultural practices or holidays you would like us to know about? _____

_____

Have they had any experiences in playing with other children that are not their siblings? Y N

With what age do they prefer to play? _____ Do they know anyone currently attending BELC? Y N

Are they typically: ☐ Friendly? ☐ Aggressive? ☐ Shy/Withdrawn?

If they do get aggressive or are shy/withdrawn, please explain what may trigger that: _____

_____

What makes them angry or upset? _____

_____

How do they show their feelings? _____

_____

What method of behavior control is used at home? _____

_____

Who does most of the disciplining? _____

How do they respond to discipline? _____

Are they frightened by:

Animals? Y N Tall people? Y N Rough children? Y N Loud noises? Y N

Dark? Y N Storms? Y N Anything else? _____

Do they have any favorite toys/activities at home? _____

_____

Do they like to: Be read to? Y N Listen to music? Y N

Do they prefer to play outdoors? Y N Can they ride a tricycle? Y N

Family, Social and Emotional History Contin.

Do they have any experience with:

Clay? Y N Scissors? Y N Blocks? Y N Fingerpainting? Y N

Easel painting? Y N Water play? Y N Chalk? Y N Sand? Y N

Are there any other challenges regarding your child that we should be aware of? _____

_____

Eating

Are they usually hungry at mealtime? Y N Between meals? Y N Are they a snacker? Y N

Are they: ☐ right handed ☐ left handed ☐ ambidextrious

Do they eat with:

Their hands? Y N A spoon? Y N A fork? Y N

What are their favorite foods? _____

What foods are refused? _____

What time do they usually eat:

Breakfast? _____ Lunch? _____ Dinner? _____

Is your family vegetarian? Y N Does your family eat pork? Y N

Are there any other dietary restrictions you would like to share with us? _____

_____

Are there any problems with eating? _____

_____

Toileting History

Are they potty trained? Y N Are they frightened of the bathroom? Y N

Do they tend to have accidents? Y N Do they need help with using the bathroom? Y N

Do they need to go more frequently than usual for their age? Y N

If yes, please explain: _____

Can they be relied upon to indicate when they need to use the bathroom? Y N

Do they wet the bed? Y N How often? _____

How do they react to accidents/wetting the bed? _____

Sleeping

Do they have their own room/bed? Y N Do they co-sleep? Y N Do they take naps? Y N

How often? _____ From when to when? _____

Sleeping Contin.

Do they resist sleep? Y N Do they have a hard time waking up? Y N

What helps to calm them? _____

What time do they usually go to bed? _____ Wake up? _____

What is their mood when they wake up? _____

Health History

Have they ever had/currently have any of the following:

- ☐ Chicken Pox
- ☐ Scarlet Fever
- ☐ Malaria
- ☐ Measles
- ☐ Mumps
- ☐ HIV
- ☐ AIDS
- ☐ Diabetes
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Tonsilitis
- ☐ Asthma

Other: _____

If yes to any of the above, please tell us at what age: _____

For children with asthma, do they have an inhaler? Y N A current action plan? Y N

Do they have frequent colds/do they get sick often? Y N Do they vomit easily? Y N

Have frequent stomach aches? Y N Ear aches? Y N Run fevers easily? Y N

Please list any allergies: _____

_____

If they have allergies, do they: Get hives? Y N Hay fever? Y N

Is there anything else we should know? _____

_____

Have they ever been hospitalized? Y N If yes, please explain: _____

_____

Have they ever had any serious accident? Y N If yes, please explain: _____

_____

Have they:

Been to the dentist? Y N Been vision tested? Y N Had their hearing tested? Y N

Do they wear corrective lenses? Y N Corrective shoes? Y N Corrective head gear? Y N

Are there any handicaps we need to be aware of? Y N Please explain: _____

_____

_____

Health History Contin.

Please give a statement of your evaluation of your child's overall health: _____

_____

_____

In Your Words

Briefly describe your child (appearance, personality, abilities, etc.): _____

_____

_____

_____

_____

What are your expectations for your child at Branford Early Learning Center? _____

_____

_____

In what particular ways can we help your child? _____

_____

_____

Is there anything else you would like us to know? _____

_____

_____

_____

What religious holidays does your family celebrate? _____

_____

_____

State of Connecticut Department of Education

Early Childhood Health Assessment Record

(For children ages birth – 5)

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 be helpful to the health care provider when he or she completes the health evaluation (Part II). State law requires complete primary immunizations and a health assessment by a physician, an advanced practice registered nurse, a physician assistant, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to entering an early childhood program in Connecticut.

Please print

Child's Name (Last, First, Middle)	Birth Date (mm/dd/yyyy)	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone / Cell Phone	
Early Childhood Program (Name and Phone Number)	Race/Ethnicity ❑ American Indian/Alaskan Native ❑ Hispanic/Latino ❑ Black, not of Hispanic origin ❑ Asian/Pacific Islander ❑ White, not of Hispanic origin ❑ Other	
Primary Health Care Provider: Name of Dentist:		
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance? Y N
Does your child have dental insurance? Y N
Does your child have HUSKY insurance? Y N

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

* If applicable

Part I — To be completed by parent/guardian.

Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Frequent ear infections	Y	N	Asthma treatment	Y	N
Allergies to food, bee stings, insects	Y	N	Any speech issues	Y	N	Seizure	Y	N
Allergies to medication	Y	N	Any problems with teeth	Y	N	Diabetes	Y	N
Any other allergies	Y	N	Has your child had a dental examination in the last 6 months	Y	N	Any heart problems	Y	N
Any daily/ongoing medications	Y	N				Emergency room visits	Y	N
Any problems with vision	Y	N	Very high or low activity level	Y	N	Any major illness or injury	Y	N
Uses contacts or glasses	Y	N	Weight concerns	Y	N	Any operations/surgeries	Y	N
Any hearing concerns	Y	N	Problems breathing or coughing	Y	N	Lead concerns/poisoning	Y	N
Developmental — Any concern about your child's:						Sleeping concerns	Y	N
1. Physical development	Y	N	5. Ability to communicate needs	Y	N	High blood pressure	Y	N
2. Movement from one place to another	Y	N	6. Interaction with others	Y	N	Eating concerns	Y	N
			7. Behavior	Y	N	Toileting concerns	Y	N
3. Social development	Y	N	8. Ability to understand	Y	N	Birth to 3 services	Y	N
4. Emotional development	Y	N	9. Ability to use their hands	Y	N	Preschool Special Education	Y	N

Explain all "yes" answers or provide any additional information:

Have you talked with your child's primary health care provider about any of the above concerns? Y N

Please list any **medications** your child will need to take during program hours:

*All medications taken in child care programs require a separate **Medication Authorization Form** signed by an authorized prescriber and parent/guardian.*

I give my consent for my child's health care provider and early childhood provider or health/nurse consultant/coordinator to discuss the 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

Part II — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation, physical examination and immunization record.

Child's Name _____ Birth Date _____ (mm/dd/yyyy) Date of Exam _____ (mm/dd/yyyy)

❑ I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider.

*HT_____in/cm_____% *Weight_____lbs._____oz /_____% BMI____/____% *HC_____in/cm_____% (Birth – 24 months) *Blood Pressure_____/____ (Annually at 3 – 5 years)

Screenings

***Vision Screening**
❑ EPSDT Subjective Screen Completed (Birth to 3 yrs)
❑ EPSDT Annually at 3 yrs (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑ Unable to assess
❑ Referral made to: _____

***Hearing Screening**
❑ EPSDT Subjective Screen Completed (Birth to 4 yrs)
❑ EPSDT Annually at 4 yrs (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
	❑ Pass	❑ Pass
	❑ Fail	❑ Fail

❑ Unable to assess
❑ Referral made to: _____

***Anemia:** at 9 to 12 months and 2 years

***Hgb/Hct:** | *Date

***Lead:** at 1 and 2 years; if no result screen between 25 – 72 months

History of Lead level ≥ 5µg/dL ❑ No ❑ Yes

***TB:** High-risk group? ❑ No ❑
Yes Test done: ❑ No ❑ Yes Date: _____
Results: _____
Treatment: _____

***Dental Concerns** ❑ No ❑ Yes
❑ Referral made to: _____
Has this child received dental care in the last 6 months? ❑ No ❑ Yes

*Result/Level: *Date

Other:

***Developmental Assessment:** (Birth – 5 years) ❑ No ❑ Yes **Type:**

Results:

*IMMUNIZATIONS ❑ Up to Date or ❑ Catch-up Schedule: MUST HAVE IMMUNIZATION RECORD ATTACHED

***Chronic Disease Assessment:**

Asthma ❑ No ❑ Yes: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent ❑ Exercise induced
*If yes, please provide a copy of an **Asthma Action Plan***
❑ Rescue medication required in child care setting: ❑ No ❑ Yes

Allergies ❑ No ❑ Yes: _____
Epi Pen required: ❑ No ❑ Yes
History/risk of Anaphylaxis: ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Medication ❑ Unknown source
*If yes, please provide a copy of the **Emergency Allergy Plan***

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II **Other Chronic Disease:** _____

Seizures ❑ No ❑ Yes: Type: _____ _____

❑ This child has the following problems which may adversely affect his or her educational experience:
❑ Vision ❑ Auditory ❑ Speech/Language ❑ Physical ❑ Emotional/Social ❑ Behavior
❑ This child has a developmental delay/disability that may require intervention at the program.
❑ This child has a special health care need which may require intervention at the program, e.g., special diet, long-term/ongoing/daily/emergency medication, history of contagious disease. *Specify:* _____

❑ No ❑ Yes This child has a medical or emotional illness/disorder that now poses a risk to other children or affects his/her ability to participate safely in the program.
❑ No ❑ Yes Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.
❑ No ❑ Yes This child may fully participate in the program.
❑ No ❑ Yes This child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.)

❑ No ❑ Yes Is this the child's medical home? ❑ I would like to discuss information in this report with the early childhood provider and/or nurse/health consultant/coordinator.

Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped ***Provider*** Name and Phone Number

Child's Name: _____ **Birth Date:** _____ REV. 3/2015

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) _____

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP/DT						
IPV/OPV						
MMR						
Measles						
Mumps						
Rubella						
Hib						
Hepatitis A						
Hepatitis B						
Varicella						
PCV* vaccine					*Pneumococcal conjugate vaccine	
Rotavirus						
MCV**					**Meningococcal conjugate vaccine	
Influenza						
Tdap/Td						

Disease history for varicella (chickenpox) _____
(Date) (Confirmed by)

Exemption: **Religious** _____ **Medical: Permanent** _____ **†Temporary** _____ **Date** _____
†Recertify Date _____ †Recertify Date _____ †Recertify Date _____

Immunization Requirements for Connecticut Day Care, Family Day Care and Group Day Care Homes

Vaccines	Under 2 months of age	By 3 months of age	By 5 months of age	By 7 months of age	By 16 months of age	16–18 months of age	By 19 months of age	2 years of age (24-35 mos.)	3-5 years of age (36-59 mos.)
DTP/DTaP/ DT	None	1 dose	2 doses	3 doses	3 doses	3 doses	4 doses	4 doses	4 doses
Polio	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
MMR	None	None	None	None	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]
Hep B	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
HIB	None	1 dose	2 doses	2 or 3 doses depending on vaccine given[3]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]
Varicella	None	None	None	None	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]
Pneumococcal Conjugate Vaccine (PCV)	None	1 dose	2 doses	3 doses	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday
Hepatitis A	None	None	None	None	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	2 doses given 6 months apart[5]	2 doses given 6 months apart[5]
Influenza	None	None	None	1 or 2 doses	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]

1. Laboratory confirmed immunity also acceptable
2. Physician diagnosis of disease
3. A complete primary series is 2 doses of PRP-OMP (PedvaxHIB) or 3 doses of HbOC (ActHib or Pentacel)
4. As a final booster dose if the child completed the primary series before age 12 months. Children who receive the first dose of Hib on or after 12 months of age and before 15 months of age are required to have 2 doses. Children who received the first dose of Hib vaccine on or after 15 months of age are required to have only one dose
5. Hepatitis A is required for all children born on or after January 1, 2009
6. Two doses in the same flu season are required for children who have not previously received an influenza vaccination, with a single dose required during subsequent seasons

_____

Initial/Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number

Child and Adult Care Food Program (CACFP)

Income Eligibility Application for CACFP Child Care Centers and Head Start

For instructions, refer to *Instructions for Income Eligibility Application for CACFP Child Care Centers and Head Start*.

Part 1 — Child's information

Child's name: _____ Age: _____ Birth date (*month, day, year*): _____

Child's normal child care schedule (*Check all days that apply):*

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Child's normal hours of care *(include time and circle AM or PM):*

_____ AM/PM to _____ AM/PM and _____ AM/PM to _____ AM/PM

Normal meal services provided to child *(Check all meals/snacks that apply):*

☐ Breakfast ☐ A.M. Snack ☐ Lunch ☐ P.M. Snack ☐ Supper

Part 2A — Participants categorically eligible as free for CACFP benefits

Households receiving Supplemental Nutrition Assistance Program (SNAP) (formerly known as Food Stamps) or Temporary Family Assistance (TFA) benefits, and households with foster children. Complete this part and part 3. Do **not** complete part 2B.

SNAP case number: _____ TFA case number: _____ Check if foster child: ☐

Part 2B — All other households

If you did not complete part 2A, complete this part and part 3.

Names of all household members *List **everyone** in the household, including the child listed in part 1 above*	**Gross income and how often it was received:** Indicate if income was received monthly, two times a month, every two weeks, or weekly by placing the **amount of income** in the appropriate frequency box. *You **must** place the income in the appropriate frequency box.*											
	Earnings from work (before deductions) – job 1				**Public assistance/ alimony/child support**				**Pensions/retirement/social security/all other income**			
Names	Weekly	Biweekly Every 2 weeks	2 X Month	Monthly	Weekly	Biweekly Every 2 weeks	2 X Month	Monthly	Weekly	Biweekly Every 2 weeks	2 X Month	Monthly
(Example) Jane Smith	$200					$134						
1.												
2.												
3.												
4.												
5.												
6.												
7.												
8.												

Part 3 — Contact information, signature, and social security number

*An adult household member must **sign and date** this form before it can be approved.*

I certify (promise) that all information on this form is true and that all income is reported. I understand that the center will receive federal funds based on the information I provide. I understand that CACFP officials may verify (check) the information. I understand if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable state and federal laws.

Printed name of adult: _____ Signature: _____

Date: _____ Last four digits of Social Security Number (SSN): XXX-XX- _____ ☐ I do not have a SSN

Home telephone: _____ Work telephone: _____

Home address: _____ City: _____ State: _____ Zip code: _____

Income Eligibility Application for CACFP Child Care Centers and Head Start

Part 4 — Racial and ethnic identity (optional) *You are not required to complete this part.*

Ethnicity *(Check one):*

- ☐ Hispanic/ Latino
- ☐ Not Hispanic/Latino

Race *(Check one or more):*

- ☐ Asian
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or other Pacific Islander

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced-price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced-price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. mail: U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410; or
2. fax: (833) 256-1665 or (202) 690-7442; or
3. email: program.intake@usda.gov

This institution is an equal opportunity provider.

CSDE
CONNECTICUT STATE DEPARTMENT OF EDUCATION

For information on the CACFP, visit the Connecticut State Department of Education's (CSDE) CACFP website or contact the CACFP staff at the CSDE, Bureau of Child Nutrition Programs, 450 Columbus Boulevard, Suite 504, Hartford, CT 06103-1841.This form is available at https://portal.ct.gov/-/media/SDE/Nutrition/CACFP/Forms/IncElig//Income_Eligibility_Application_CACFP_Centers.pdf.

For sponsor use only – Do not write below this line

Annual income conversion: Weekly X 52 • Every 2 weeks X 26 • Twice a month X 24 • Monthly X 12

Total family income: $ _____ Family size: _____ **OR** ☐ SNAP/TFA household ☐ Foster child

☐ Eligible Free ☐ Eligible Reduced ☐ Over Income

Sponsor eligibility official: _____ Date: _____

Signature

Child and Adult Care Food Program (CACFP) Child Enrollment Form for Child Care Centers

Our child care center participates in the U.S. Department of Agriculture (USDA) CACFP. This program helps us provide nutritious meals and snacks to children enrolled in our center. For information on the CACFP meal pattern requirements, review the CACFP Meal Patterns for Children and the CACFP Infant Meal Patterns at https://portal.ct.gov/SDE/Nutrition/Meal-Patterns-CACFP-Child-Care-Programs.

Section 1 – Waiver of CACFP participation

Check here **only** if you are choosing **not** to enroll your child in the CACFP. *Complete section 3 on page 2, and return to the child care center.*

☐ I do not want my child to participate in the CACFP.

Section 2 – CACFP enrollment

To verify your child's enrollment in this child care center, complete this section and section 3 on page 2, and return to the child care center. You may be contacted by the center, the Connecticut State Department of Education, or the USDA to verify this information. *Please print all information.*

Child care center's name: ______________________________

Child's name: ______________________________ Birth date: ______________
Last name *First name* *Month, day, year*

☐ Male ☐ Female First day of attendance: ______________

Complete the chart below. My child will normally be in child care during the following days and times, and will receive the meals indicated below.

Days and hours of care and meals served							
Normal days of care *Check all that apply*	☐ **Monday**	☐ **Tuesday**	☐ **Wednesday**	☐ **Thursday**	☐ **Friday**	☐ **Saturday**	☐ **Sunday**
Normal hours in care *Circle AM or PM*	____ AM/PM to ____ AM/PM and ____ AM/PM to ____ AM/PM	____ AM/PM to ____ AM/PM and ____ AM/PM to ____ AM/PM	____ AM/PM to ____ AM/PM and ____ AM/PM to ____ AM/PM	____ AM/PM to ____ AM/PM and ____ AM/PM to ____ AM/PM	____ AM/PM to ____ AM/PM and ____ AM/PM to ____ AM/PM	____ AM/PM to ____ AM/PM and ____ AM/PM to ____ AM/PM	____ AM/PM to ____ AM/PM and ____ AM/PM to ____ AM/PM
Meals normally served to my child *Check all that apply*	☐ Breakfast ☐ AM snack ☐ Lunch ☐ PM snack ☐ Supper ☐ Evening snack	☐ Breakfast ☐ AM snack ☐ Lunch ☐ PM snack ☐ Supper ☐ Evening snack	☐ Breakfast ☐ AM snack ☐ Lunch ☐ PM snack ☐ Supper ☐ Evening snack	☐ Breakfast ☐ AM snack ☐ Lunch ☐ PM snack ☐ Supper ☐ Evening snack	☐ Breakfast ☐ AM snack ☐ Lunch ☐ PM snack ☐ Supper ☐ Evening snack	☐ Breakfast ☐ AM snack ☐ Lunch ☐ PM snack ☐ Supper ☐ Evening snack	☐ Breakfast ☐ AM snack ☐ Lunch ☐ PM snack ☐ Supper ☐ Evening snack

For infants only

Infant formula: The center offered to serve: _____

*Name of approved iron-fortified infant formula **

Check all that apply:

- ☐ I would like my child to receive the above named iron-fortified infant formula supplied by the center.
- ☐ I will provide my own infant formula: _____

  *Name of approved iron-fortified infant formula **
- ☐ I will provide expressed breast milk for my child.
- ☐ I will breastfeed my child on site in the center.

* **Note:** Infant formula provided by the parent/guardian must be **iron-fortified** and comply with the USDA's infant formula regulations indicated in USDA Memo CACFP 02-2018: *Feeding Infants and Meal Pattern Requirements in the Child and Adult Care Food Program; Questions and Answers*. Infant formulas that do not meet these requirements cannot be substituted unless an infant has a disability that restricts his/her diet, and the parent/guardian provides a medical statement signed by a recognized medical authority. Recognized medical authorities include physicians, physician assistants, doctors of osteopathy, and advanced practice registered nurses (APRNs). Medical statements are available on the Connecticut State Department of Education's (CSDE) Special Diets in CACFP Child Care Programs webpage.

Section 3 – Contact information and signatures

Parent/guardian name: _____

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

Work phone (with area code): _____ Home phone (with area code): _____

Parent signature: _____ Date: _____

Sponsor representative's signature: _____ Date: _____

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
(2) fax: (202) 690-7442; or
(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

CSDE
CONNECTICUT STATE DEPARTMENT OF EDUCATION

For information on the CACFP, visit the CSDE's CACFP website or contact the CACFP staff at the Connecticut State Department of Education, Bureau of Child Nutrition Programs, 450 Columbus Boulevard, Suite 504, Hartford, CT 06103-1841.This form is available at https://portal.ct.gov/-/media/SDE/Nutrition/CACFP/Forms/Enroll/CACFP_Enrollment_Form_Centers.pdf.

PARENT DIRECTORY PERMISSION

By completing this form, you are providing information for a directory that will be shared exclusively with families enrolled at Branford Early Learning Center.

The directory serves as a resource for arranging playdates, sending birthday invitations, coordinating snow day shared care, or simply building new friendships. **Share only the details you feel comfortable with**, and each family will receive a copy of the completed directory.

Child's Name: _____

Parent(s)/Legal Guardian(s) Names: _____

_____

Address: _____

_____

Phone number(s): _____

_____

Email address': _____

_____

Signature of Release: _____ Date: _____

PERMISSION TO PHOTOGRAPH/VIDEO

As part of our educational program and school community events, opportunities may arise for your child to be photographed, video-recorded, or audio-recorded. These images or recordings may be used in various ways including, but not limited to:

- Brightwheel
- Newsletters
- Our school website and/or Facebook page
- State Accreditation portfolios
- Staff training materials
- Local television or newspapers
- Public performances
- Classroom displays or projects

In order to grant or deny permission, please complete this form and return it to the front office.

☐ I give permission for my child, _____, to be photographed, video-taped and/or audio-taped for the following:

- ☐ Brightwheel
- ☐ BELC's website
- ☐ BELC's Facebook page
  - ☐ Private
  - ☐ Public
- ☐ BELC Newsletters
- ☐ State Accreditation portfolios
- ☐ Staff training materials
- ☐ Public performances
- ☐ Classroom displays and/or projects
- ☐ Local newspapers or television
- ☐ Group photos
- ☐ Individual photos

Brightwheel only? **Y** **N**

☐ I DO NOT give permission for my child, _____, to be photographed, video-taped and/or audio-taped at all.

By signing below, I understand and agree that Branford Early Learning Center, INC. may use such media for my child (if permission is granted) with or without names, for lawful purposes including publicity, illustration, adverrtising, and web content

Parent/Guardian Signature: _____ Date: _____

SUNSCREEN/INSECT REPELLENT PERMISSION

There will be times your child is taken outside for free play, when the weather permits. To ensure that no child gets burned, we require that you bring in sunscreen/sunblock (creams/lotions, please no spray) of SPF 30 or above, labeled with your child's name, for us to apply before we take your child outside. We will continue to apply it as needed.

I, _____, give BELC permission to apply sunscreen as needed

Parent/Legal Guardian Signature: _____

If you would like us to apply an insect repellent, you must supply it, labeled with your child's name. Children must be older than 2 months in order for us to apply it and it will not be applied more than once daily.

I, _____, give BELC permission to apply insect repellent once daily, when needed

Parent/Legal Guardian Signature: _____

BELC

BRANFORD EARLY LEARNING CENTER

Parental Consent

Child's Name: _____ Date:_____

I have read the Parent Handbook, including the Illness Policy. I agree to adhere to the Branford Early Learning Center, Inc. policies including those outlined in the Handbook and hereby give my child permission to participate fully in the program.

Name of Parent/Legal Guardian (printed): _____

Signature of Parent/Legal Guardian: _____ Date: _____

I have reviewed and agree to the Discipline Policy of Branford Early Learning Center, Inc.

Name of Parent/Legal Guardian (printed): _____

Signature of Parent/Legal Guardian: _____ Date: _____

I have read the Fee Policy of Branford Early Learning Center, Inc. in the Parent Handbook.

Name of Parent/Legal Guardian (printed): _____

Signature of Parent/Legal Guardian: _____ Date: _____

FOR PARENTS OF INFANTS ONLY:

I have read the Infant Sleep Arrangement Policy of Branford Early Learning Center, Inc. in the Parent Handbook and have signed the acknowledgment form.

Name of Parent/Legal Guardian (printed): _____

Signature of Parent/Legal Guardian: _____ Date: _____

Branford Early Learning Center Parent Agreement

I understand that my fee is due and payable regardless of attendance or Center closings. Fee will be paid once a month, due on the 15th of the month. Fees will be calculated using the CT Office of Early Childhood formulas. There is a late fee of $25 for payments made after the 15th. I agree to pay and be liable for the monthly fee of $_____. A fee of $35 will be applied for all returned checks. Failure to pay may lead to my child being excluded from the program.

I understand that on state holidays, days that school will be closed due to bad weather, two vacation weeks per year and one week in August; the program will not be open. Please refer to the school calendar for specific dates.

If my child is having behavior or adjustment problems, I, the parent, will be expected to remove the child from the Center at the Director's request, if needed.

In the event of illness, vacation, or other absences, I will notify staff by either Brightwheel or telephone (203-488-4512) in a timely manner.

The staff will assume full responsibility for my child from arrival until dismissal. Dismissal time will be promptly at 5:00 pm or earlier. My child must be signed in upon arrival and signed out only by an authorized person. Late fees of $5 per every portion of 5 minutes, will apply in the event that I am late picking up my child. If I am continuously late, I may be asked to leave the program.

I give permission for my child to participate in field trips (you will be given prior notice and a permission slip will need to be signed) where they will take a school bus, to go on walks in the immediate vicinity and to participate in on-site activities such as dance, music, soccer, yoga, sign language and Spanish.

If a medical emergency arises, the staff will first attempt to contact me or one of my emergency contacts. If I cannot be reached, the staff will contact the child's doctor. If the emergency requires immediate attention from a hospital, the staff may call 911 and accompany my child to the hospital. Emergency medical care my be given in the event that I cannot be contacted immediately.

Routine first aid may be given by staff. The school is allowed to notify me if concerns arise after first aid has been given.

I give permission for the staff to do confidential testing for the purpose of evaluating my child and to create an appropriate learning/behavioral/social program for him/her. This information will not be disclosed outside of the program without parental permission.

I have read and signed the Permission to Photograph/Video form for my child.

I agree that in case of an emergency my child may be transported to a place of safety, such as the Branford Community House. Every effort will be made to contact parents as soon as possible.

The Center's Discipline Policies have been reviewed prior to enrollment and may be reviewed at any time with the Center staff.

I have read the Illness Policy and understand that my child will be required to be picked up immediately, should they fall ill while at the Center.

I have received and reviewed the Parent Handbook. I agree to abide by all the policies and rules set forth.

I AGREE AND ADHERE TO THE BRANFORD EARLY LEARNING CENTER, INC. POLICIES, INCLUDING THE DISCIPLINE POLICY AND THOSE OUTLINED IN THE PARENT HANDBOOK. I GIVE MY CHILD PERMISSION TO PARTICIPATE FULLY IN THE PROGRAM.

ENROLLMENT IS NOT COMPLETE UNTIL ALL PAPERWORK IS COMPLETE AND RETURNED.

Parent/Legal Guardian Signature: _____ Date:_____

Date child is to begin: _____ Fee:_____

Parent/Guardian Authorization for the Administration of

Non-Prescription Topical Medications by Child Care Personnel (one per medication)

To Child Care Personnel:

I hereby request that the following non-prescription topical medications be administered to my child by a child care staff member of the **Branford Early Learning Center**.

I understand that I must supply the child care program with the non-prescription topical medication in the original container labeled with the child's name, name of the medication, and the directions of the medication administration. This authorization is limited to the following topical medications:

1. Diaper changing or other ointments free of antibiotic, antifungal or steroidal medications

2. Medicated powders

3. Teething, gum, or lip medications

Name of Child: _____Date of Birth:_____

Address:_____

Name of Medication:_____

Schedule of Administration:_____

Site of Administration:_____

Reason medication is being administered:_____

Medication shall be administered from:_____ to:_____

Name of Parent/Guardian_____ Date:_____

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

Signature:_____ Relationship to child:_____

Address:_____ Telephone:_____

Staff to complete: Parent authorization form and medication received by:_____
(Signature of staff) Medication Started:_____(date and time)
Medication Ended:_____(date and time)

Parent permission and medication administration record shall become part of the child's health record when the medication has ended.