INTAKE FORMS CHECKLIST

Child's Name:

_____

_____

DOB:

_____

Please return the following enrollment requirements:

___ Copy of Birth Certificate

___ Copy of 1040 Tax Form or W2 or 4 weeks' pay stubs.

___ Emergency Numbers & Pick-up Authorization Form

___ Child Enrollment & Emergency Medical Care Form

___ Child/Family Personal History Form (4 pages)

___ Early Childhood Health Assessment Record *(child's "physical")*

___ Infant *or* Toddler Development History Form OR Infant Development History Form

___ CACFP (Required for All Children): Income Eligibility Application

___ CACFP (Required for All Children): Child Enrollment Form

___ Parent Directory Permission Form

___ Permission to Photograph /Video/Image Form

___ Sunscreen and Insect Repellent Permission Form

___ Parental Consent Form

___ Branford Early Learning Center (BELC) Parent Agreement

___ ACH form for tuition payments *(if applicable)*

___ Permission for Topical Medication *(if applicable)*

___ Authorization for Medication Administration from Doctor *(if applicable)*

___ Non-Refundable $100.00 Registration Fee

Also included for Family:

- ✓ BELC School Calendar
- ✓ Parent Handbook (paper or electronic PDF)
- ✓ Welcome Letter from Teachers
- ✓ Supply List for Classroom

After completion, family will receive Brightwheel app login information.

EMERGENCY NUMBERS & PICK-UP AUTHORIZATION

ENROLLMENT DATE: _____ DOB: _____

CHILD'S NAME: _____

HOME PHONE NUMBER: _____

ADDRESS: _____

MOTHER'S NAME: _____

MOTHER'S ADDRESS (IF DIFFERENT): _____

MOTHER'S PLACE/ ADDRESS OF EMPLOYMENT: _____

_____

MOTHER'S BUSINESS PHONE: _____ MOTHER'S CELL PHONE: _____

MOTHER'S EMAIL: _____

FATHER'S NAME: _____

FATHERS'S ADDRESS (IF DIFFERENT): _____

FATHER'S PLACE/ ADDRESS OF EMPLOYMENT:

_____

FATHER'S BUSINESS PHONE: _____ FATHER'S CELL PHONE: _____

FATHER'S EMAIL: _____

PHYSICIAN'S NAME: _____ PHONE: _____

CHILD'S INSURANCE COMPANY: _____ POLICY NUMBER: _____

DENTIST'S NAME: _____ PHONE: _____

PERSONS OTHER THAN PARENTS ALLOWED TO BE CONTACTED IN AN EMERGENCY & ALLOWED TO PICK UP CHILD:

1). _____ RELATIONSHIP: _____ PHONE: _____

2). _____ RELATIONSHIP: _____ PHONE: _____

3). _____ RELATIONSHIP: _____ PHONE: _____

OTHERS ALLOWED TO PICK UP:

1). _____ RELATIONSHIP: _____ PHONE: _____

2). _____ RELATIONSHIP: _____ PHONE: _____

3). _____ RELATIONSHIP: _____ PHONE: _____

CHILD WILL NOT BE RELEASED TO ANYONE NOT LISTED ON THIS FORM. A Photo ID is required for identification or people who are not known to staff. If parents are divorced or separated, or in a situation where child custody is questioned, Branford Early Learning Center, Inc must have all court ordered action with regard to custody and/or visitation and care of children. **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 FORM

Date of Application: _____ Date of Enrollment: _____ Last Day of Enrollment: _____
Child's Name: _____ Child's Date of Birth: _____
Child's Address: _____ City: _____ Zip Code _____
Mother's Name: _____Address: _____
City: _____ Zip Code: _____e-mail Address: _____
Home Telephone #: (_____) _____ Cell #: (_____) _____
Mother's Employer: _____ Work #: (_____) _____
Mother's Employer Address: _____ City: _____ Zip Code _____
Father's Name: _____Address: _____
City: _____ Zip Code: _____e-mail Address: _____
Home Telephone #: (_____) _____ Cell #: (_____) _____
Father's Employer: _____ Work #: (_____) _____
Father's Employer Address: _____ City: _____ Zip Code _____

****

Weekly Care Schedule: (please include the child's hours in care for each day)
Sunday: _____
Monday: _____
Tuesday: _____
Wednesday: _____
Thursday: _____
Friday: _____
Saturday: _____

Persons permitted to remove the child from the child care program on behalf of parent. (Use back for additional names.)
Name: _____
Phone #: _____Relationship _____

****

In an emergency, adults to be contacted if parent cannot be reached and to whom the child can be released.
(Use back for additional names.)
Name: _____
Phone #: _____Relationship _____

****

Medical Information

Known Allergies: _____ Last Tetanus: _____
Insurance Carrier: _____ Insurance ID: _____

Child's Physician: Name: _____ Phone #: (_____) _____
Address _____ City:_____ Zip Code: _____
Child's Dentist: Name: _____ Phone #: (_____) _____
Address _____ City:_____ Zip Code: _____

****

Emergency Authorization

I give my consent for the First Aid and CPR certified staff of **(program's name)** _____, 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 in the event of a medical emergency. I will be responsible for all medical fees.
Preferred Medical Facility: _____

****

Behavior Management and Parent Handbook

I acknowledge that I have read the parent handbook and agree to abide by the policies contained in it and that the techniques used to manage child behaviors in the facility have been discussed with me prior to enrollment.

Signature of Parent or Guardian: _____ **Date**: _____

Signature of Parent or Guardian: _____ **Date**: _____

CHILD/FAMILY PERSONAL HISTORY

The purpose in securing this information about your child is to help the child care staff better understand your child and to help you know what to expect from the child care center. 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. Please use the back sides of this form if you wish to elaborate more on a question. Some questionns may not be applicable to your child at this time. If that is the case, please leave them blank.

Family and Social History

Telephone _____

Name of Child _____ Birthdate _____

Mother (or Guardian) _____ Age _____

Father (or Guardian) _____ Age _____

Marital Status of Parents:

Married _____ Divorced _____ Seperated _____ Single Parent _____
How long? How long?

Remarks _____

Social Security Numbers: Mother _____ Father _____

Custody/Visiting Arrangements _____

Siblings Name _____ Birth Date _____
Name _____ Birth Date _____
Name _____ Birth Date _____

Other members of the household (include relationship and age):

_____

_____

_____

How long have you lived in this city? _____

Do you speak a language at home other than English? _____

Are there any special words that would help us communicate with your child? _____

_____

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

_____

CHILD/FAMILY PERSONAL HISTORY

Personal History

Type of Birth: Full Term _____ Premature _____

Any complications? _____

Age he/she began sitting _____ Crawling _____ Walking _____

Is he/she a good climber? _____ Does he/she fall easily? _____

Age he/she bagan talking? _____ Does he/she speak in words? _____ Sentences? _____

Does he/she have any speech problems? _____

Sleeping

What time does child go to bed? _____ Awaken _____

Is he/she ready for sleep? _____ Does he/she have his own room? _____

Own bed? _____ Does he /she walk, talk, cry out at night? _____

What is his/her mood on awakening? _____

Does he/she take naps? (from when to when?) _____

Social Relationships

Has she/he had experiences in playing with other children? _____

By nature, is he/she friendly? _____ aggressive? _____ shy or withdrawn? _____

How does he get along with siblings? _____

Other adults? _____

With what age does he/she prefer to play? _____

Will he/she know any children in the center? _____

Do you feel he/she will adjust easily to the child care situation? _____

What makes him/her angry or upset? _____

How does your child show his/her feelings? _____

_____

What method of behavior control in used in your home? _____

What is child's typical reaction? _____

CHILD/FAMILY PERSONAL HISTORY

Who does most of the disciplining? _____

Is he/she frightened by any of the followir animals? _____ tall people? _____

rough children? _____ loud noises? _____ dark? _____ storms? _____

Anything else? _____

Favorite toys & activities at home? _____

Does he/she like to be read to? _____ Listen to music? _____

Does he/she prefer to play outdoors? _____ Can your child ride a tricycle? _____

Has he or she had experience with clay? _____ scissors _____ blocks _____

finger painting _____ easel painting _____ water play _____

Does your child have any other problems/challenges we should be aware of? _____

Health History of Child

What past illnesses has he/she had? At what age?

Chicken pox	_____	Scarlet fever	_____	Diabetes	_____	Malaria	_____
HIV	_____	AIDS	_____	Measles	_____	Hepatitis A	_____
Hepatitis B	_____	Mumps	_____	Other	_____		

Does your child have frequent colds? _____
Explain _____

Tonislitis? _____ Ear Aches _____ Stomach Aches _____

Does he/she vomit easily? _____ Run high fevers easily? _____

Has your child had any serious accidents? _____

Does your child have allergies? _____ Asthma _____ Hay fever _____

Hives _____ Other _____ Do you know the cause? _____

Has your child been hospitalized? _____ What for? _____

Has your child seen a dentist? _____ Vision tested? _____

Hearing tested? _____ Does he/she wear corrective shoes? _____

Does your child have any handicaps? Explain _____

Please give a statement of your evaluation of your chid's overall health. _____

CHILD/FAMILY PERSONAL HISTORY

Eating

Is child usually hungry at mealtime? _____ between meals? _____

What are his/her favorite foods? _____

What foods are refused? _____

What eating problems does the child have? _____

Any food allergies? _____

Does child eat with a spoon? _____ fork? _____ hands? _____

Is child left or right handed? _____ What time does your child usually eat breakfast? _____

Lunch? _____ Dinner? _____ is family vegetarian? _____

Other dietary restrictions _____

Toilet Habits

Can the child be relied upon to indicate his toileting wishes? _____

What word is used for urination? _____ Bowel movements? _____

Does the child need to go more frequently than usual for his age? _____

Is he/she frightened of the bathroom? Does he/she have accidents?

How does he/she react to them? _____

Does child need help with toileting? _____

Was the child easy or difficult to toilet train? _____

Does the child wet his/her bed at night? _____ How often? _____

Briefky describe your child (appearance, personality, abilities) _____

_____

_____

What are your expectations for your child at the center? In what particular ways can we help your child?

_____

_____

_____

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 1) which will be helpful to the health care provider when he or she completes the health evaluation (Part 2) and oral health assessment (Part 3). 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/Alaska Native ❑Native Hawaiian/Pacific Islander ❑Asian ❑White ❑Black or African American ❑Other ❑Hispanic/Latino of any race	
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 1 — 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

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); Public Act No. 18-168.

Part 2 — 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 ❑nNo ❑nYes

*__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
Seizures ❑No ❑Yes: Type: _____

Other Chronic Disease: _____

❑ 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

Part 3 — Oral Health Assessment/Screening

Health Care Provider must complete and sign the oral health assessment.

To Parent(s) or Guardian(s):
State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

Student Name (Last, First, Middle)	Birth Date	Date of Exam
School	Grade	❑Male ❑Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination	**Visual Screening**	Normal	**Referral Made:**
Completed by: ❑Dentist	Completed by: ❑MD/DO ❑APRN ❑PA ❑Dental Hygienist	❑Yes ❑Abnormal (Describe) _____ _____ _____ _____ _____	❑Yes ❑No

Risk Assessment	**Describe Risk Factors**	
❑Low	❑Dental or orthodontic appliance	❑Carious lesions
❑Moderate	❑Saliva	❑Restorations
❑High	❑Gingival condition	❑Pain
	❑Visible plaque	❑Swelling
	❑Tooth demineralization	❑Trauma
	❑Other_____	❑Other _____

Recommendation(s) by health care provider: _____

_____

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

_____

Signature of Parent/Guardian Date

_____

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

Child's Name:_____ **Birth Date:**_____ REV. 1/2022

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	
Flu						
Other						

Religious Exemption: _____

Religious exemptions must meet the criteria established in Public Act 21-6: https://www.ctoec.org/wp-content/uploads/2021/07/OEC-Vaccination-QA-Final.pdf.

Medical Exemption: _____
Must have signed and completed medical exemption form attached.
https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/infectious_diseases/immunization/CT-WIZ/CT-Medical-Exemption-Form-final-09272021fillable3.pdf

Disease history of varicella: _____(date); _____(confirmed by)

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	2–3 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	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]
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 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

INFANT DEVELOPMENT HISTORY

Date: _____

Child's Name: _____Called: _____

Birthdate: _____ Gender: _____

HEALTH:

Does your child seem well most of the time? Yes No

Is your child taking any medication? (Including Tylenol, laxatives, vitamins) Yes No

If yes, what? _____ Why? _____

Has your child had as many as 3 ear infections? Yes No

Are you concerned about your child's hearing? Yes No

Has your child had more than 3 colds with fever? Yes No

Are you concerned about your child's eyes or vision? Yes No

Has your child been seen by a medical specialist? Yes No

If Yes, who? _____

Why? _____

What arrangements have you made for the care of your child should he/she become ill at the Center? _____

Does your child any handicaps? _____

If yes please describe_____

Other illness or disease? Limitation?

_____

Has your child been hospitalized? Yes No Why? _____

_____

Has your child had any of the following? Please circle

Premature Birth, Seizures, Hives, HIV, Hepatitis A, B, Trouble Breathing, Head Injury, Broken Bones, Bee Sting, Allergies (eczema, hives, food intolerance, food intolerance, hay fever, wheezing, asthma, insect stings). _____

DEVELOPMENTAL HISTORY:

How do you comfort your child? _____

Does your child have a favorite toy? _____

What is your child's favorite activity? _____

What language is spoken at home? _____

SLEEPING:

Do you have any specific ways of helping your child go to sleep? _____

_____

Does your child cry when going to sleep? Yes No

What is your child's current sleep schedule?

Night time: from: _____ to: _____

AM nap: from: _____ to: _____

PM nap: from: _____ to: _____

Does your child use a pacifier for naptime? Yes No

Does your child use a special toy at naptime? Yes No

Does your child use a blanket at naptime? Yes No

FEEDING:

Is your child breast fed? Yes No Bottle fed? Yes No

Type of bottle: _____

Does your baby need to be burped? Yes No

What is your child's eating schedule? (Please specify amounts)

	Juice	Food	Milk/ Formula
Breakfast:	_____	_____	_____
Lunch:	_____	_____	_____
Snack:	_____	_____	_____

Does your child have any feeding problems? Yes No If yes, what are they?

_____

TOILETING:

How frequently does your child have a bowel movement? _____

Appearance of bowel movement: _____

Does your child have diaper rash often? _____

How is it treated? _____

FAMILY INPUT:

Is there any information you would like us to know about your child or family?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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

We would like to have your permission to include your personal information in a directory given only to other families enrolled in Branford Early Learning Center. The directory can be used to schedule play dates, birthday invitations, snow day shared care, or making a new friend. Please fill out whatever information you are comfortable with giving and I will type a directory for each family.

Child's name:

_____

Parent(s)' names:

_____

Address:

_____

Phone number(s):

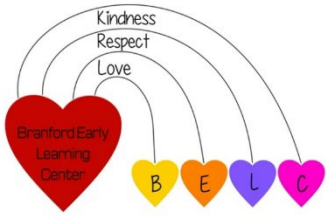
_____

Email address:

_____

Parent's signature of release:

_____



BRANFORD EARLY LEARNING CENTER, Inc. 16 Birch Rd., Branford, CT 06405 Tel: 203.488.4512

PERMISSION TO PHOTOGRAPH/VIDEO/IMAGE

In conjunction with the educational programs in our school, opportunities occur to photograph or video your child. These images may be used in the school, in newsletters, on the school website, in school portfolios for State Accreditation, on television, to train staff members, as part of a public performance, or on the school's Facebook page.

In order to grant the school permission to photograph and/or video your child, we ask parents/guardians of all students must complete and return the form below.

I hereby

- **Give** permission for my child, _____
- **Do Not Give** permission for my child, _____

To be photographed, video-taped, audio-taped, named on radio, named or shown on television, named or pictured in a newspaper, on the school's website, on the schools Facebook page, and/or appear in a public performance (which may be photographed or video-taped).

I agree that Branford Early Learning Center, Inc. may use such photographs of me with, or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising and Web content.

I have read and understand the above:

Signature: _____

Printed Name: _____

Classroom: _____

Date: _____

SUNSCREEN/INSECT REPELLENT PERMISSION

We require that you bring in sunscreen/sunblock (lotion, no spay please) of SPF 30 or above labeled with your child's name for us to apply on your child's exposed skin before going outside. It will be applied during the day as needed.

If you want insect repellent to be applied, you must supply it, labeled with your child's name. It must be on children older than 2 months. We will apply it no more than once daily.

I give my permission for my child to have sunscreen applied

_____

I give permission for my child to have insect repellant applied

_____

PARENTAL CONSENT

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.

Printed Name of Parent _____

Child's Name_____

Signature of Parent_____ **Date** _____

I have read, discussed, and agree to the discipline policy of Branford Early Learning Center, Inc.

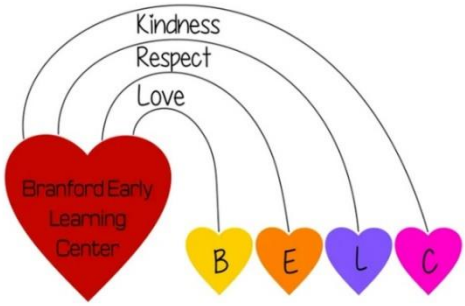
Printed Name of Parent_____

Signature of Parent_____ **Date** _____

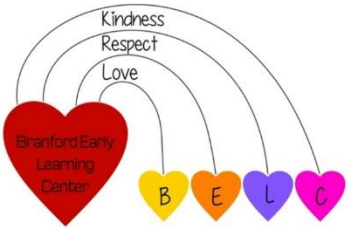
I have read the fee policy of Branford Early Learning Center, Inc. on page 6 of the Parent Handbook.

Printed Name of Parent _____

Signature of Parent_____**Date** _____



Branford Early Learning Center Parent Agreement



1. 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 and divided into 12. **There is a late fee of $25.00 dollars for a payment made after the 15th. I agree to pay and be liable for the weekly fee ($_____ per month). A fee of $35 will be applied for all returned checks.**
2. I understand that on state holidays, days that school will be closed because of bad weather, and two vacation weeks per year, there will be no program.
3. 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.
4. In the event of illness, vacation, or other absences, staff must be notified in the morning. (203) 488-4512.
5. 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 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.
6. I give permission for my child to participate in field trips (parents will be given prior notice and permission slips will need to be signed), to go on walks in the immediate vicinity, and to participate in on-site activities such as dance, music, yoga, drama, sign language, and Spanish.
7. 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 is such that immediate hospital attention is needed, the staff may call 911, and accompany my child to the hospital. Emergency medical care may be given in the event that I cannot be contacted immediately.
8. Routine first aid may be given by staff. The school nurse will be called if concerns arise (and then the school will notify me).
9. Fees must be paid in advance. Failure to pay may lead to my child being excluded from the program.
10. 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 the program without parental permission.
11. I have read and signed the Photography Policy Form for my child.
12. In the case of civil or other 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.
13. The Center's Discipline Policies^ have been discussed prior to enrollment and may be reviewed at any time with the Center staff.
14. I have read the Illness Policy^ and understand that my child will be required to be picked up immediately if ill.
15. I have received and read the Parent Handbook and agree to abide by all the policies and rules set forth.

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

Enrollment is not complete until all paperwork is complete and returned. Thank you.

Parent or Legal Guardian's Signature:_____ Date:_____

Date child is to begin: _____Fee:_____

^in Parent Handbook.

Branford Early Learning Center
16 Birch Road
Branford, CT 06405
(203) 488-4512

Authorization for ACH Credit/Debit Tuition Payments

I (we)_____hereby authorize Branford Early Learning Center, Inc. to initiate entries to my (our) account (and, if necessary, initiate adjustments for any transactions credited/debited in error) as follows:

Select One: _____Checking Account _____Savings Account

At the depository financial institution named below ("DEPOSITORY"). I (we) agree that ACH transactions I (we) authorize comply with all applicable law.

Depository Name:_____

Routing Number:_____ **Account Number:**_____

Name(s) on the Account:_____

Select One: _____Business Account _____Personal Account

Please attach copy of voided check to this form.

Set Amount: $_____ or **Maximum amount:** $_____

Select One:

Date(s) and/or frequency of payment(s): _____Day 1 of month _____Day 15 of month

This authority will remain in effect until Branford Early Learning Center, Inc is notified by me (us) in writing to cancel it in such time as to afford the COMPANY and the DEPOSITORY a reasonable opportunity to act on it.

Name(s):_____(please print)

Signature(s):_____Date:_____

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.