



WOMEN
& FAMILIES
CENTER

169 Colony Street
Meriden, CT 06451

Phone # (203) 235.9297 FAX # (203) 237.7571

Website: www.womenfamilies.com

Child Care Enrollment Application Before and After School Programs 2009 – 2010

Sponsor's Name _____ Email Address _____

Child's Name _____

Program: (check one) Hale _____ Hanover _____ Pulaski _____

Schedule: (check one) AM _____ PM _____ AM & PM _____ Drop-in _____

How did you hear about our program? (check one) _____ Website (specify) _____

_____ Newspaper (specify) _____ Referral (specify) _____

_____ Returning family _____ Flyer _____ Other (specify) _____

For office use only

Date application received _____ Staff initials _____ Complete _____ Incomplete _____

Date application was completed _____ Staff initials _____

Parent contact:

Date:	Date:	Date:

Women and Families Center Childcare Approved Rates per Week

Effective 2009 - 2010

Program	Level 1	Level 2	Level 3
Before School	\$35.00	\$40.00	\$45.00
After School	\$45.00	\$50.00	\$55.00
Before & After School	\$75.00	\$85.00	\$95.00
Late Fee	\$15.00 every 15 minutes, or part there of that a parent/guardian is late picking up a child		
Non – Refundable Application Fee Deposit	\$30.00 annually Equal to 1 week of Child’s weekly fee		

- Families with more than 1 child receive a 10% discount off each additional child’s weekly fee.
- A Non – Refundable \$30.00 Application fee is due upon registration. We require 5 business days to process an application. After this process, you will be contacted on the amount of tuition to pay.
- Deposit payment as well as 1st week tuition must be paid prior to the child’s start date. (Deposit payment will remain on file and will be applied to the last week of service)

Please provide the following information about your child/family. It is required for statistical purposes only because our agency receives state funds. It does not affect your admission to our program in any way.

Family Composition

Total # members in family
 Guardian Foster Parent
 1 parent 2 parents
 Working Other

Federal Programs Participation

TFA
 CCAP
 Jobs First
 Other

Enrollment Application Checklist

**The following are all required. Return completed form with documents to Director, Child Care Services
Incomplete applications will not be processed.**

<i>For office use only</i>	<i>For office use only</i>	<i>For office use only</i>
<input type="checkbox"/> \$30 Non-Refundable application fee		
<input type="checkbox"/> Proof of income: copy of three (3) most recent pay stubs, Employer Letter, State Budget Letter, or signed income waiver		
<input type="checkbox"/> Current Care 4 Kids certificate/application for program (parent’s initials if N/A _____)		
<input type="checkbox"/> Complete Enrollment Information		
<input type="checkbox"/> Current Emergency Information (3)		
<input type="checkbox"/> Signed Payment Policy Agreement		
<input type="checkbox"/> Signed Policy for Picking Up a Child		
<input type="checkbox"/> Current Physical and Immunization Record		
Enrollment date _____	Approved Start Date: _____	
Tuition Type _____ Rate: _____	Single child _____	Additional Child _____ 2 nd Child Discount _____
Non-Refundable Application Fee _____	1 Week Deposit _____	
Reviewed by: _____		_____
Name		Date

Enrollment Information

Enrollment Date _____

Child's Name _____ **D.O.B** _____
Last Name First Name

Age _____ **Boy** _____ **Girl** _____ **Race** _____ **Social Sec. #** _____

Address _____
St # Apt # City State Zip-Code

Insurance Company _____ **Public** _____ **Private** _____ **Hospital** _____

Primary Doctor's Name _____ **Telephone #** _____ **Dentist's name** _____ **Telephone #** _____

Any special considerations: (Medical conditions, allergies, diet restrictions, I-E-P (related to educational needs or assistance), custody issues):

Guardian 1 Relationship to child _____

(if applicable)
Guardian 2 Relationship to child _____

Last name First name

Last name First name

Address: _____
(Street and Apt#)

Address: _____
(Street and Apt#)

City State Zip-Code

City State Zip-Code

Home Tel. # Cellular #

Home Tel. # Cellular #

Work Place & Tel. _____
Tel. #

Work Place & Tel. _____
Tel. #

Work Address: _____
Street # City State zip-code

Work Address: _____
Street # City State zip-code

Emergency Contacts ** Contacts must be different than the above guardians.

The following people are authorized to pick-up my child(ren) or be contacted in case of emergency. **(Must be 16 or older)**

1 - Name: _____ Relationship to child: _____

Address _____

License / I.D. #

Tel:#

Alternate Tel #

2 - Name: _____ Relationship to child: _____

Address _____

License / I.D. #

Tel:#

Alternate Tel #

3 - Name: _____ Relationship to child: _____

Address _____

License / I.D. #

Tel:#

Alternate Tel #

I give permission for First Aid to be administered by an appropriate staff member, to my child (ren): _____ in the event of an emergency. I understand I will be called if my child is ill and needs to be picked up (or an alternate emergency contact, if I cannot be reached). I grant permission for my child to be transported to a hospital by emergency vehicle and to receive emergency medical treatment, at any medical facility, if I am not able to be present.

Signature of Parent/Guardian _____

Date _____

Women and Families Center

ENROLLMENT INFORMATION FOR OTHER CHILDREN FOR SAME FAMILY & SAME PROGRAM

Child's Name _____ **D.O.B** _____
Last Name First Name

Age _____ **Boy** ___ **Girl** ___ **Race** _____ **Social Sec. #** _____

Address _____
St # Apt # City State Zip-Code

Insurance Company _____ **Public** ___ **Private** ___ **Hospital** _____

Primary Doctor's Name Telephone # Dentist's name Telephone #

Any special considerations: (Medical conditions, allergies, diet restrictions, I-E-P (related to educational needs or assistance), custody issues):

Child's Name _____ **D.O.B** _____
Last Name First Name

Age _____ **Boy** ___ **Girl** ___ **Race** _____ **Social Sec. #** _____

Address _____
St # Apt # City State Zip-Code

Insurance Company _____ **Public** ___ **Private** ___ **Hospital** _____

Primary Doctor's Name Telephone # Dentist's name Telephone #

Any special considerations: (Medical conditions, allergies, diet restrictions, I-E-P (related to educational needs or assistance), custody issues):

Child's Name _____ **D.O.B** _____
Last Name First Name

Age _____ **Boy** ___ **Girl** ___ **Race** _____ **Social Sec. #** _____

Address _____
St # Apt # City State Zip-Code

Insurance Company _____ **Public** ___ **Private** ___ **Hospital** _____

Primary Doctor's Name Telephone # Dentist's name Telephone #

Any special considerations: (Medical conditions, allergies, diet restrictions, I-E-P (related to educational needs or assistance), custody issues):

WOMEN AND FAMILIES CENTER (WFC)

**BEFORE AND AFTER SCHOOL PROGRAM PAYMENT POLICY
2009-2010 SCHOOL YEAR**

At the time of registration, parents are responsible to pay a **Non-refundable \$30 Application Fee**. We require five (5) business days to process your application. Upon completion of this process, you will be contacted by phone with the amount of your deposit and weekly tuition payment.

- **Deposit payment is due after application is processed. It will remain on file in your account and will be applied to the last week of service.**
- **The 1st Week Tuition Payment can be paid at the same time you make your deposit payment, but no later than one week before your child's start date.**
- **Tuition payments for each week are due on the Friday before the week of service.**
- **Tuition payments are to be made weekly.**

The WFC offers a sliding scale for fees based on family's gross weekly income. Copies of 3 current pay stubs are required to determine tuition rate.

- **Parents/Guardians are obligated to pay the weekly fee, regardless of time missed due to holidays, weather closings, illness, personal vacations, early departures or early closings.**
- **WFC requires one week's notice, in writing, for withdrawal. The security deposit is applied to the last week of service.**

After missing a payment, a parent will receive a "1st Notice of Missed Payment" on the Tuesday following the due date. This notice will state the amount and date due in order to avoid withdrawal proceedings. After two missed payments parents/guardians will receive a notice stating that their child can not return until the balance is paid. The child will not be accepted back into the program until the past due amount is paid, provided we have a space available.

If a parent/guardian receives Child Care assistance from a third party payer (i.e. Care-4-Kids, DCF), paperwork must be submitted before the child starts. Parents/Guardians are required to make payment arrangements until a Child Care Certificate or recertification Certificate has been received. If a recertification certificate is not received by the expiration date of the previous certificate, it is the parent/guardian's responsibility to pay full tuition until recertification is received. After receiving a certificate, parents/guardians are responsible for paying their parent share payments according to the above stated policy.

Families applying for Care 4 Kids (CCAP) must deliver their application and required documents to our Child Care Accounting Assistant within two (2) weeks of enrollment. If you need assistance in filling out the application the Child Care Accounting Assistant will be glad to help. If there are any changes in your Care-4-Kids status, income, family size or child care payments for other children in the household, please see the Child Care Accounting Assistant immediately. This could affect your rate. Families which have Care-4-Kids will not pay more than our weekly rate, but may have to pay more than the family share listed on their certificate. We will calculate your rate on a sliding scale. Care-4-Kids pays only for your work hours that match your child care hours.

For your convenience, the Child Care Accounting Assistant and Coordinator are available to explain our policies and these procedures;

- Provide you a copy of your fee determination and explain how your family's contribution was determined.
- How fees are assessed.
- How income, family size, DSS cash assistance status and any other eligibility factors are determined and verified.
- How confidentiality is maintained.
- Procedures for failing to pay, loss of a job, or appealing a fee determination.

I have read the above policy and agree to the terms for payment of tuition.

Signature

Date

Witness

Date



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Serving Connecticut families for over 100 years

Dear Parent/Guardian:

If you do not want to provide proof of income, please read and sign below.

As part of the enrollment process, we require parents/guardians to provide us with proof of income. Failure to provide proof of income places you over income and you will be charged the level III fee (highest tuition level).

WFC receives grant funds that require us to do statistical reports. Income information is used for this purpose as well as determining your weekly tuition rate.

Name of child: _____

Program: _____

Parent/Guardian's Signature: _____

Date: _____

If you should have any questions, please call Rebecca @ 235.9297 ext. 138.

Main Office: 169 Colony Street Meriden Connecticut 06451-3283 Phone: 203.235.9297 Fax: 203.237.7571





WOMEN & FAMILIES CENTER

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BEFORE & AFTER SCHOOL PROGRAM DROP IN POLICY

- Any child from the BOE School Site may participate.
- All child participants must have an application on file in the main office and on site, complete with updated physical.
- All applications must be complete with a \$30.00 non-refundable registration fee. Processing could take up to a week.
- Drop In is conditional with space availability, does not exceed teacher: child ratios at the site and “first come, first serve” policy.
- Parent must call ahead of time. Parent must call site’s telephone number for a reservation.
- **Cost is a per day rate of \$25.00 (attendance for AM and PM), due when entering the day of attendance (paid in advance). *Half days will be \$35 per day. AM only is \$10 a day. PM only and BOE early closings are \$15 a day.***

I have read and understand the above in regards to WFC Before & After School Program Drop-In Policy.

Parent/Guardian Signature

Date

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Women and Families Center

POLICY FOR PICKING UP A CHILD

Parents must maintain an up to date Alternate Pickup List. Parents are required to inform the program when there will be someone other than a parent or person on the Alternate Pickup List picking up the child. This person must be at least 16 years of age and present picture identification.

- If someone not on the Alternate Pickup List arrives to pick up a child and the parent can not be reached, the child WILL NOT be released to that person.
- If anyone, including a parent, comes to pick up a child and they are not familiar to the staff, the staff is required to ask for identification.
- If any information on the ALTERNATE PICK UP LIST changes, the parent must inform the program in order to update information in the child's file.
- Parents (or other authorized adult) **must** sign the child in and out **each** day.
- There is a late fee of \$15.00 for every fifteen minutes, or part there of, that a parent is late picking up his/her child. This fee must be paid before the child returns to the program. After three late pick-ups, a meeting will be held to develop an action plan. If the child continues to be picked up late, it may result in termination from the program.

Closing time for Before and After School Program is 5:30pm

I have read the POLICY FOR PICKING UP A CHILD for the Women and Families Center.

Signature

Date

WOMEN AND FAMILIES CENTER

**MERIDEN PUBLIC SCHOOL
STORM CLOSINGS AND DELAYS
2009-2010**

**PLEASE FOLLOW THE MERIDEN PUBLIC SCHOOL
ANNOUNCEMENTS MADE ON:**

RADIO STATIONS:

WTIC-1080 AM and 96.5 FM
WELI 960 AM
WMMW 1470 AM (Spanish)
WKCI 101.3 FM
WKSS 95.7 FM
WWYZ 92.5 FM
WDRC 102.9 FM and 1360 AM

TELEVISION CHANNELS:

3 – WFSB-TV
4-WVIT-TV
8 – WTNH-TV

WEBSITES:

www.wtnh.com
www.wfsb.com
www.wtic.com
www.nbc30.com

X: /word/snowclosing stations

Adopted: 1/7/2005

Revised: 1/28/2005, 3/29/07, 5/14/08, 3/12/09

WOMEN AND FAMILIES CENTER

Before & After School Program Closings 2009-2010

Sept. 7 - Labor Day
Oct. 9 – Professional Development
Oct. 12 - Columbus Day
Nov. 3 – Election Day
Nov. 11 – Veterans Day
Nov. 26-27 Thanksgiving Holiday
Dec. 24-Jan. 1 Holiday Recess
Jan. 18 – Martin Luther King, Jr. Day
Feb. 15-19 Winter Vacation
Apr. 2 – Good Friday
Apr. 12-16 Spring Vacation
May 31 – Memorial Day



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Photograph Permission Form

I do give permission for my child (print name), _____ to be photographed by the staff of the Women & Families Center. I understand my child's photo may be used for displays, brochures, advertising, or other forms of marketing, and educational purposes.

OR

I do **not** give permission for my child (print name), _____ to be photographed by the staff of the Women & Families Center. I understand my child's photo will not be used for displays, brochures, advertising, or other forms of marketing, and educational purposes.

Parent/Guardian Signature _____

Date _____

Main Office: 169 Colony Street Meriden Connecticut 06451-3283 Phone: 203.235.9297 Fax: 203.237.7571





State of Connecticut Department of Education Health Assessment Record



To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part II).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, a physician assistant or the school medical advisor prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 10th or 11th grade. Specific grade level will be determined by the local board of education.

Please print

Name of Student (Last, First, Middle)		Social Security Number	Birth Date	Sex
Address (Street)		Race/Ethnicity		
(Town and ZIP code)		<input type="checkbox"/> American Indian <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> Other		
Home Telephone Number	School			Grade
Name of Parent/Guardian (Last, First, Middle)				
Health Care Provider		Health Insurance Company/Number* or Medicaid/Number*		

* If applicable

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

Part I — To be completed by parent

**Important: Complete Part I before your child is examined.
Take this form with you to the health care provider's office.**

Please check answers to the following questions in columns on the left.
(Explain all "yes" answers in the space provided below.)

- | | Yes | No | |
|-----|--------------------------|--------------------------|---|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any concerns about your child's general health (overall eating and sleeping habits, teeth, etc.)? |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Has your child been diagnosed with any chronic disease <input type="checkbox"/> asthma <input type="checkbox"/> diabetes <input type="checkbox"/> seizure disorder <input type="checkbox"/> other _____ |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any allergies (food, insects, medication, latex, etc.)? |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child take any medications (daily or occasionally)? |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any problems with vision, hearing or speech (glasses, contacts, ear tubes, hearing aids)? |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | Has your child had any hospitalization, operation, major illness or injury, or significant accident? (Please specify.) |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | In the last 12 months, has your child experienced any difficulty with wheezing, excessive coughing or excessive night waking? (Please specify.) |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | In the last 12 months, has your child experienced any difficulty with excessive weight loss or weight gain, or excessive thirst or urination? (Please specify.) |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have health insurance? (If your child does not have health insurance, call 1-877-CT-HUSKY) |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have dental insurance? |
| 11. | <input type="checkbox"/> | <input type="checkbox"/> | Would you like to discuss anything about your child's health with the school nurse? |

Please explain any "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

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

Signature of Parent/Guardian _____
Date

Part II — Medical Evaluation

HAR-3 REV. 4/2006

To the Health Care Provider: Please complete and sign.

Student's Name _____ Birth Date _____ has had a complete history and physical exam on _____ Month/Day/Year

Findings for this student are as follows:

Screening/Test Results			Immunization Record					
Note: * Mandated Screening/Test under Connecticut State Law			Vaccine (Month/Day/Year) Note: * Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.					
* Height:		BMI:	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
* Weight:		* Postural:	DTP	*	*	*	*	
* Blood Pressure:		<input type="checkbox"/> Normal	DTP/Hib					
Pulse:		<input type="checkbox"/> Abnormal	DTaP					
* HCT/HGB:		Min. _____	DT/Td					
Urinalysis:		Slight _____	OPV	*	*	*		
* Gross dental:		Mod. _____	IPV	*	*	*		
Lead (Date/Result)		Marked _____	MMR					
TB and Other Test Results (Sickle Cell, etc.)			Measles	*	*		Booster for entry into K and 7th grade	
TB: In high-risk group? <input type="checkbox"/> Yes <input type="checkbox"/> No			Mumps	*				
Test	Date	Results	Rubella	*				
			HIB	*			Students under age 5	
			Hep B	*	*	*	Req. for entry into K and 7th grade.	
* Vision/ Type of Screening	* Auditory/ Type of Screening		Varicella	*			Students born 1/1/97 or later. Required for 7th grade entry.	
With glasses R L	Pass/Fail		PCV				Pneumococcal conjugate vaccine	
20/ 20/	R		Other Vaccines (Specify)					
Without glasses R L	L							
20/ 20/								
* Chronic Disease Assessment:			Disease Hx					
Yes No			of above _____ (Specify) _____ (Date) _____ (Confirmed by)					
<input type="checkbox"/> <input type="checkbox"/> Asthma: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe			<p style="text-align: center;">Exemption</p> Religious _____ Medical: Permanent _____ Temporary _____ Date _____ Recertify Date _____ Recertify Date _____ Recertify Date _____					
<input type="checkbox"/> <input type="checkbox"/> exercise induced <input type="checkbox"/> unclassified								
<input type="checkbox"/> <input type="checkbox"/> Diabetes: <input type="checkbox"/> Type I <input type="checkbox"/> Type II								
<input type="checkbox"/> <input type="checkbox"/> Anaphylactic Reaction: <input type="checkbox"/> food <input type="checkbox"/> insect <input type="checkbox"/> latex								
<input type="checkbox"/> <input type="checkbox"/> Seizure Disorder								
<input type="checkbox"/> <input type="checkbox"/> Other: Please specify _____								
Date of onset _____								
This student has the following problems which may adversely affect his or her educational experience:								
<input type="checkbox"/> Vision <input type="checkbox"/> Auditory <input type="checkbox"/> Speech/Language <input type="checkbox"/> Physical Dysfunction <input type="checkbox"/> Emotional/Social <input type="checkbox"/> Behavior								
<input type="checkbox"/> The pupil has a health condition which may require emergency action at school, e.g., seizures, allergies, anaphylaxis. <i>Specify below.</i>								
<input type="checkbox"/> The pupil is on long-term medication. <i>Specify below.</i>								
Comments and recommendations (additional information about any of the above health assessment): _____								

<input type="checkbox"/> This student may participate fully in the school program, including physical education activities.								
<input type="checkbox"/> This student may participate in the school program and physical education with the following restriction/adaptation. <i>(Specify reason and restriction.)</i> _____								
<input type="checkbox"/> Yes <input type="checkbox"/> No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.								
<input type="checkbox"/> I would like to discuss information in this report with the school nurse.								
Signature of health care provider			Name/Group Practice (Please type or print.)			Phone Number		

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

Vision Auditory Speech/Language Physical Dysfunction Emotional/Social Behavior

The pupil has a health condition which may require emergency action at school, e.g., seizures, allergies, anaphylaxis. *Specify below.*

The pupil is on long-term medication. *Specify below.*

Comments and recommendations (additional information about any of the above health assessment): _____

This student may participate fully in the school program, including physical education activities.

This student may participate in the school program and physical education with the following restriction/adaptation. *(Specify reason and restriction.)* _____

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

I would like to discuss information in this report with the school nurse.

Signature of health care provider _____ Name/Group Practice (Please type or print.) _____ Phone Number _____