Dear Families,

Welcome to the Naugatuck YMCA Preschool and Early Learning center. We are very excited to have you become part of our YMCA family and look forward to getting to know you and your family.

Below is a check list of what you need to enroll your child in our program. Please make sure that you have all of the following information completely filled out and included with the enrollment packet. Incomplete packets may hold up the enrollment process.

Infant and Toddler Families:

- Application (must be completely fill out)
- Health Assessment Record / Physical (Parents fill out first page)
- Parent Survey
- Care 4 Kids Application (if applying for assistance)
- YMCA Membership Application (Complete front page and sign waiver on the bottom of back side)
- CACFP Application (read and complete parts 1,2 or 2a, 3 and 4)

Preschool Classrooms

- Application (must be completely fill out)
- Health Assessment Record / Physical (Parents fill out first page)
- Parent Survey
- Care 4 Kids Application (if applying for assistance)
- YMCA Membership Application (Complete front page and sign waiver on the bottom of back side)
- Birth Certificate
- Proof of Residency
- Proof of Income

  W2's, Paystubs (4 if weekly, 2 if bi-weekly, 2 if monthly)
- CACFP Application (read and complete parts 1,2 or 2a, 3 and 4)

***** If your child has allergies, asthma or any health issues that may require medication to be here at school, all forms and doctors signatures must be complete before your child can start. *****


the
"WHERE CHILDREN PLAY TO
LEARN & LEARN TO PLAY"
NAUGATUCK YMCA PRESCHOOL & EARLY LEARNING CENTER

Child Care Application

Student Information:

Child's Name: _____ Gender M F Date of Birth _____/_____/_____

Address: _____City: _____ Zip Code: _____

Home Phone:_____ Child lives with: ___ Mother ___Father ___ Grandparents ___ Foster Family

Race / Ethnicity: ____ White ____ Asian/Pacific Islander _____ American Native/ Alaskan Native _____ Black, not of Hispanic origin
____ Hispanic ____Other

Income: ____ Below 20,000 ____20,000-30,000 ____30,000-40,000 ____40,000-50,000 ____ over 50,000

Days (Infant and Toddlers only) ___M __T __W __R __F Hours: _____ a.m. to _____ p.m.

Family Information:

Parent 1 _____
Address:_____
City _____State_____Zip Code_____
Home Phone_____
Cell Phone:_____
Email _____
Employer _____
Employer Address _____
Work Phone _____

Parent 2 _____
Address _____
City _____State____ Zip Code _____
Home Phone _____
Cell Phone _____
Email _____
Employer _____
Employer Address _____
Work Phone _____

Permission to Release and Emergency Contacts (Other than parents). **Persons picking up must be at least 18 and provide a photo ID when picking up. Copies of ID's will be taken:**

Name: _____ Relationship: _____
Home: _____ Cell: _____
Name: _____ Relationship: _____
Home: _____ Cell: _____
Name: _____ Relationship: _____
Home: _____ Cell: _____
Name: _____ Relationship: _____
Home: _____ Cell: _____

Please list any person(s) who are not allowed to pick up your child. Any person who is not allowed to pick up said child must provide a copy of the restraining order or court order.

_____

_____

Siblings:

Name	Ages	Birthdate

Medical Information:

Doctor:_____

Address: _____Phone Number: _____

Dentist:_____

Address: _____Phone Number: _____

TUITON PAYMENTS

Tuition is paid on the Friday before the upcoming week. Payments are to be set up for automatic withdrawl on a debit card, credit card or bank draft. If there is insufficient funds in your account and your payment gets declined, you will be charged $30.00 fee.

Electronic Funds Transfer (EFT) Agreement

I/we hereby authorize the Naugatuck YMCA to charge the account provided on a weekly basis in the amount named, to pay for the Naugatuck YMCA Childcare program for the child(ren) listed below until the child(ren) leave the program.

_____ _____

Child's Name Child's Name

___ BANK DRAFT EFT ___ Checking ___ Savings

NAME ON CHECKING ACCOUNT _____

BANK NAME _____

ROUTING NUMBER _____

ACCOUNT NUMBER _____

___ CREDIT CARD EFT CARD TYPE: ___MasterCard ___Visa

NAME ON CREDIT CARD _____

CC # _____ Exp. Date _____

Date of First Transfer: _____ Payment Amount: _____

My signature below states my understanding that I have agreed for the Naugatuck YMCA to draft my credit card/ bank account for all fees owed for the childcare program including any late pick up fees that may occurr. I understand that I will be responsible for any and all returned payment fees that are accrued in the event that my selected payment method is not accepted.

SIGNATURE: _____ DATE: _____

Fees are due **weekly** on a prepaid basis (the Friday before the upcoming week). The yearly tuition is based on 50 weeks of school regardless of school closings or absences. The YMCA does participate in the Care4Kids program. Parents are responsible to make all weekly payments until a certificate is issued from Care4Kids and a parent share fee has been determined. **You will NOT receive a monthly bill or payment reminder unless your account is delinquent.** Delinquent accounts are cause for termination from the program.

I have read the policies and procedures of the YMCA Child Care Center and off- site programs which include, but are not limited to tuition, late fees, absenteeism, holidays, vacations, center closings, special events and termination and I understand these regulations and agree to comply.

Parent/Guardian's Signature _____ Date _____/_____/_____

CONTRACTUAL AGREEMENT

The following contract is between _____ and the Naugatuck YMCA Preschool and Early Learning Center, located at 284 Church Street, Naugatuck for the children listed below.

Child's Name _____ Date of Birth _____
Child's Name _____ Date of Birth _____
Child's Name _____ Date of Birth _____

Tuition and Payment Policies:

Infant / Toddler:		**Preschool**	
5 Days a week	$ 250.00	Private Pay	$200.00
3 days a week	$ 187.50	School Readiness Slots	$ based on income
2 days a week	$ 125.00		

My weekly tuition is $_____.

- I am in the process of applying for Care 4 Kids. My tuition will be $_____ until I receive my Care 4 Kids certificate. Once the certificate is received my tuition will be calculated and I will be responsible for any and all money owed to the Naugatuck YMCA Preschool and Early Center while waiting for my certificate to be approved. If my certificate gets canceled, I understand that I am responsible for paying the full tuition.

- Tuition is due every Friday and should be set up on autodraft apon enrollment into the program. If your account has insufficient funds and the payment doesn't go through, then you will be charged a $30.00 fee.

- Tuition is paid if your child is out sick, on vacation, if we are closed for inclement weather, delayed open or early dismissal or for professional development days. There will not be any prorated days. The center may close up to 5 additional days for professional development. A 30 day notice will be given.

- There is a late fee for picking up children after 5:30 pm when we close. The late fee is $25.00 for the first 5 minutes and $1.00 for each additional minute after the first 5 minutes. Payment for late pick up will be added to your account and fee will be taken out using the credit card on file.

Termination Procedure

This contract begins on _____, 20___ and may be terminated by either parent/guardian or provider by giving a two weeks written notice. The provider may terminate the contract without notice if the parent/guardian is at least 2 weeks late with scheduled payments. Parents who do not give 2 weeks notice will be charged for those two week to the account on file.

Signatures:
By signing this contract, all parties agree to all of the above terms and policies, including financial responsibility for child care provided. The provider is responsible for providing all parties a copy of the signed contract.

_____ _____
Parent/Guardian Signature Date

_____ _____
Director Date

PERMISSIONS

I _____, parent of _____ give permission for my child to participate in normal program activities in and away from the child care center including swim instruction, physical fitness instruction, walks to the library, St. Francis Field, our playground,walks around the block or to the town green. I voluntarily agree to hold the YMCA harmless for injuries or accidents resulting in bodily injury or property damage during my child's participation in the Naugatuck YMCA Prescool and Early Learning Center. I further waive, release, absolve and indemnify the Naugatuckc YMCA, its directors, volunteers, officers or employees for injuries or accidents occurring while participating in the programs at the YMCA.

_____
Initials

I, the undersigned, certify that the information given to the YMCA is accurate. I realize that I am responsible for updating the YMCA staff of any changes to my child's file. I understand that I must have an updated medical form for my child at the Naugatuck YMCA before they start the program. I have read and understand the Parent Handbook and have reviewed the Behavior Management Plan and discussed any concerns with staff. Also, I know that I am responsible to uphold the policies and procedures as stated.

_____
Initials

Naugatuck YMCA staff has permission to administer basic first aid and/or CPR to my child.

_____
Initials

Naugatuck YMCA Staff has permission to call 911 and have my child transported to a local hospital for medical treatment when I cannot be reached or when delay would be dangerous to my child's health. We will transport them to Waterbury Hospital.

_____
Initials

Consent
I understand that my child's health and safety file is confidential and give permission to Naugatuck YMCA Preschool and Early Learning Center's teachers and Adminstrators to access my Child's file.

_____
Initials

Photos and Social Media
I give permission for the YMCA Preschool to take pictures of my child for displays in the classroom, in hallways, on classtag and in newsletters. I give permission for my child photo to be displayed on the Naugatuck YMCA's preschool Page on social media or to be submitted to local newspapers.

_____
Initials

Public Schools
I give the Naugatuck YMCA Preschool to share my child's information with the Board of Education, Kindergarten Teachers, or school they will be attending after attending preschool.

_____
Initials

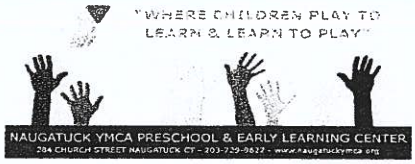
Tuition
I understand that I am responsible for my child(ren) tuition each week whether I am in a grant funded Slot, private pay slot or receiving Care4Kids. Failure to may my weekly payments may result in my child loosing her slot at the Naugatuck YMCA Preschool and Early Learning Center.

_____
Initials

Closing Policy
I understand the the Naugatuck yMCA Preschool and Early Learning Center may close for for up to 10 professional development days each year. May close early, have a delayed opening or close for inclement weather, natural disaster or building emergency (ex. no heat, no power)

_____
Initials

_____ _____
Name Date



PARENT/CAREGIVER INFORMATION SURVEY

Child's Name: _____ Child's Date of Birth: _____

FAMILY BACKGROUND AND GENERAL DEVELOPMENT

__ African American __ White __ American Indian/Alaskan ___ Native Asian/Pacific Islander

__ Other: _____

Primary language in the home: __ English __ Spanish __ Other: _____

Are you interested in learning English? ___ yes ___ no

Do you celebrate any holidays? Which ones? _____

Do you have any special traditions that you do as part of these holidays?

_____

Are there any special traditions that you and your family do that are not holiday related?

_____

Who has legal custody? ___Mother ___Father ___ Shared Custody __Other(foster home, relative, etc.)

Marital status of parents: ___Married ___Single ___ Widowed __ Separated ___ Shared custody

Adults in the home: ___Two biological parents ___ Adopted ___ Foster parent(s)
___ Mother with partner ___ Father with partner ___ Other: _____

What names does your child call you and family members (mom, dad, mommie, papa etc) _____

_____

Where do you live? __house __apartment __condo __ vehicle __shelter __friend/family __homeless

Do you need assistance to get your own place? ___yes ___no

Have you completed the following? __ high school/GED __some college __ college degree __ technical/tradeschool

Do you? __ work __go to school __ stay at home parent __ retired

Would you like information about going back to school or furthering your education? __yes __no

Do you feel you are able to provide you family with enough food to get through the week? __yes __no

Do you receive food assistance? __yes __no If yes, from where _____

Is your child part of the CACFP (Child And Adult Care Food Program) ? __yes __ no

Would you like information to help you get assistance to get food for your family ? __yes __ no

Do you receive services from the department of Social Services? __ yes __ no

If yes what services do you receive? _____

Please describe any major family or parental stressors that may have impacted your child in the past or that may impact him or her now: _____

_____

Are there any particularly traumatic or troubling events which have happened in your child's life which we should know about in order to understand him/her better? (please give details, include incidents you feel were traumatic for your child.) _____

_____

Has your child ever witnessed violence inside or outside of the home? ___ yes ___ no
If Yes, please give details below: _____

_____

TOILETING / POTTY TRAINING

My child shows an interest in using the potty. _____yes ____no
My child wears ____diapers ____pull ups ____underwear

What is used at home? Potty chair _____ special child seat _____ regular seat _____

How does your child indicate bathroom needs (include special words)_____

_____

Is your child ever reluctant to use the bathroom_____

Does the child have accidents? _____ How often?_____

EDUCATIONAL EXPERIENCES

Has the child been in other childcare Center(s) or family childcare home(s)? _____Yes ____No
If yes, how many different placements? _____
If yes, how long ago was the most recent placement? _____
How often did your child attend this program? _____ Full Time ____ Full Days (2-3 Days a week)
_____ Part Time ____ 2 days a week ___ 3 days a week
Does the child have an: ____IEP _____ IFSP ____ None
Is the child attending any other program (therapy, speech etc.)? __Yes __No
Is the child or family receiving services from Department of Social Services? __Yes __No
If yes, which services? _____

Do you have any concerns with your child pertaining to the following?
__ Attention __ Anxiety __Disruption __ Hyperactivity __ Pica (eating non-edible items)
__ Seems Depressed __ Self Injury __Withdrawn __ Somatic (excessive complaints of physical ailments)
__ Other _____

When did behavioral difficulties begin? _____
Are there any significant changes in the child's life? _____When? _____
Does the child have a diagnosis or diagnoses? __Yes __No Please check all that apply.
__ Attention-Deficit Hyperactivity Disorder __ Bi-Polar Disorder __ Autism Spectrum Disorder
__Speech and Language Delay __ Cognitive Delay __ Developmental Delay
__Sensory Impairment __ Physical Disability __Other : _____

PHYSICAL DEVELOPMENT

Any concerns about child's motor skills (i.e. walking, sitting, crawling)? __Yes __No
Does your child: __sit with support __sit unsupported __crawl forward/backward __ stand
__walk with assistance __ walk unassisted __run __go up steps __ go down steps
Does your child use primarily one hand when eating, coloring, and throwing, or do they switch hands frequently?
_____Yes _____No If yes, which hand is used most often _____

Please check under the word that best describes your child.

	Good	Average	Needs Help	Not Applicable
Uses scissors				
Uses crayons				
Uses pencils				
Climbs				
Walks				
Runs				
Hops on 1 foot				
Jumps				

Please check under the word that best describes your child.

	Good	Average	Needs Help	Not Applicable
Uses words to express self				
Speaks clearly				
Vocabulary is age appropriate				
Understands directions				

COMMUNICATION

How many words does the child use? _____
Does the child put words together? (2 – 3 word sentences) ___Yes ___No
Does the child make any sounds? (i.e. car sounds, animal sounds) __Yes __No
Example: _____
Does your child use primarily one hand when eating, coloring, and throwing, or do they switch hands frequently?
_____Yes _____No If yes, which hand is used most often _____

SWIMMING:

As part of our curriculum we provide weekly swim lessons to the children.
Has your child had swim lessons ? ___ yes ___ no If yes, how many years experience: _____
Can your child swim with out a floatation device? _____ yes _____ no
Is your child afraid of the water? _____ yes _____ no
How does your child react when they go into a pool, pond or ocean? _____
_____
Do you know how to swim? _____ yes _____ no
Are you interested in learning how to swim? _____ yes _____ no

GOALS FOR YOUR CHILD

What would you like your child to gain from this child care experience? _____
_____
Is there any information which you might like to share that would help us in understanding and caring for your child? _____
_____
How can our staff support you and your child in reaching these goals? _____
_____

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

MEMBERSHIP APPLICATION

Membership Category: ☐ Full Facility Member ☐ Community Member

Youth - High School - Young Adult - Adult - Senior - Couple - Family - Single Adult Family
Active Older Adult - Active Older Couple—Third Party: _____

Primary Adult Member

First Name		MI	Last Name		Date
Gender	DOB	Marital Status		Race (Optional)	
Mailing Address		City	State	Zip	
Home Phone	Cell Phone	E-mail			
Emergency Contact	Relationship	Home Phone	Cell Phone		

Additional Adult Member

First Name		MI	Last Name		Date
Gender	DOB	Marital Status		Race (Optional)	
Home Phone	Cell Phone	E-mail			

Additional Household Member

First Name	MI	Last Name	DOB	Gender	Adult/Youth
First Name	MI	Last Name	DOB	Gender	Adult/Youth
First Name	MI	Last Name	DOB	Gender	Adult/Youth
First Name	MI	Last Name	DOB	Gender	Adult/Youth

HOW DID YOU HEAR ABOUT THE YMCA?

Member Friend Ad Internet Live in Area Direct Mail

Payment Options & YMCA Authorizations

- I understand that I am authorizing the Naugatuck YMCA to implement a monthly automatic debit/bank withdrawal from my checking or savings account to pay my monthly YMCA membership dues.
- I authorize the YMCA to debit/charge the account or card identified in the payment method section below. I certify that the such account/card exists and I agree to maintain said account/card with sufficient funds to permit said debit/charge. I understand that this bank/credit card company account/card will be kept on file electronically for charges to my YMCA account.
- Terminations: I understand that I must submit written notice of cancellation to terminate said monthly automatic debit/ bank withdrawal 5 business days prior to said change. The YMCA agrees and will terminate the said pre-authorized debit/charge within 48 hours of receipt of termination.
- Account Changes/Medical Holds: I agree to notify the Naugatuck YMCA of any account changes. I understand all account changes/holds must be made at least 5 business days prior to the next pre-authorized debit/withdrawal or charge.

Payment Method/Authorization Agreement

Draft Date: ____3rd or ____ 17th

☐ Debit/Withdrawal from Checking/Savings Account

Bank Name: _____

Bank Address: _____

_____

Please show proof of Account and Routing number

☐ Charge Debit or Credit Card

☐ Visa ☐ MasterCard ☐ American Exp. ☐ Discover

Name on Card: _____

Billing Address of Card Holder: _____

_____

- Naugatuck YMCA monthly membership is a continuous plan which automatically renews monthly
- Naugatuck YMCA, at their discretion, may adjust the monthly rate of membership. I will receive at a minimum of 5 business days' notice prior to any membership change.
- Should any YMCA account debit or charge not be honored by my bank or credit company for any reason, I am still responsible for that payment and incur a $25 service charge for the non honored charge.
- Naugatuck YMCA reserves the right to terminate my membership for non-payment of membership charges

Signature

I have read and agree to the above terms and duration of this agreement:

Member Signature: _____ **Date:** _____

Liability & Membership Waiver

Use of the YMCA facilities and participation in sports or other physically demanding activities inherently exposes the participant to a certain degree of risk of personal injury, illness, and other adverse medical consequences. The YMCA in not an insurer of a member's life or personal safety. No member will engage in activities which require a level of physical fitness exceeding the member's physical condition or abilities, as determined by the member. Every member assumes the risk of personal injury , illness, or other conditions arising out of or related to the member's activities on YMCA premises and releases the YMCA, it's Directors Officers, Agents, and Employees from all claims, actions, or liability on account of such causes. Members and /or services of the Naugatuck YMCA for any form of compensation.

I am an adult over 18 years old of age and wish to participate in Naugatuck YMCA membership/program activities. IN CONSIDERATION of being permitted to utilize the facilities, services and programs of the YMCA for any purpose, including , but not limited to observation or use of facilities or equipment ,or participation in any off-site program affiliated with the YMCA, the undersigned ,for himself or herself and any personal representatives, heirs, and next of kin, hereby acknowledges, agrees and represents that he or she has, or immediately upon entering or participating inspected and carefully considered such premises and facilities or the affiliated program. In addition, I give my children permission to participate in Naugatuck YMCA activities. I understand that even when every reasonable precaution is taken, accidents can sometimes happen. Therefore, in exchange for allowing me to participate in YMCA activities , I understand and expressly acknowledge that I, for myself ,or anyone entitled to act on my behalf, waive and release the YMCA, sponsors, representatives ,and successors from all claims or liabilities of any kind arising out of my participation in activities at or sponsored by the YMCA. I further agree to indemnify and save harmless the YMCA, its staff director's members and guests. I have read, understand, and am voluntarily signing this authorization and release.

I understand that the Naugatuck YMCA is not responsible for personal property lost, damaged or stolen while members and / or program participants are using YMCA facilities, on YMCA premises, or involved in YMCA programs. I give my permission to the Naugatuck YMCA to use limitation and obligation, photographs, film footage, or tape recordings which may include my image or voice for the purpose of promotion or interpreting YMCA programs.

By participating in the YMCA Nationwide Membership Program, I agree to release the National Council of Young Men's Christian Associations of the United States of America, and its independent and autonomous member associations in the United States and Puerto Rico, from claims of negligence for bodily injury or death in connection with the use of YMCA facilities, and from any liability for other claims, including loss of property, to the fullest extent of the law. The YMCA conducts regular sex offender screening on all members, participants, and guests. If a sex offender match occurs, the YMCA reserves the right to cancel membership, end program participation, and remove visitation access.

Signature

I have read and agree to the Liability & Membership Waiver and certify that all information provided in this application is accurate and complete

Member Signature: _____ **Date:** _____

COMPLETED BY YMCA STAFF		Staff Initials:
Member ID:	MFA: Yes or No	MFA level:

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: _____

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, 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 complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: How to File a Complaint, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter 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 Connecticut State Department of Education's (CSDE) CACFP website or contact the CACFP staff in the CSDE's Bureau of Health/Nutrition, Family Services and Adult Education, 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

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