BOYS & GIRLS CLUB
OF NORTHERN WESTCHESTER

REGISTRATION
Early Childhood Education 2017-2018
SEPTEMBER 5th, 2017 -AUGUST 17th, 2018

THIS DAY CARE FACILITY PARTICIPATES IN THE CHILD AND ADULT CARE FOOD PROGRAM (CACFP), A FEDERAL PROGRAM THAT PROVIDES HEALTHY MEALS AND SNACKS TO CHILDREN RECEIVING DAY CARE.

Todays Date: _____

_____50 Week Program 7:30am -6pm (Child must be 3 Years Old by December 1st 2017 and Fully Toilet Trained)
_____42 Week Program (Child must be 3 Years Old by December 1st 2017 and Fully Toilet Trained)
_____8 Week Summer Only Program (Child must be 3 Years Old by December 1st 2017 and Fully Toilet Trained)
_____Deposit $325 per Child

Parents Full Name _____ Home # _____

Address _____ Cell # _____

_____ Work # _____

Email Address _____

Child's Full Name _____ Male _____ Female _____ D/O/B _____

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

Child's Full Name _____ Male _____ Female _____ D/O/B _____

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

INFORMATION STRICTLY CONFIDENTIAL

Number in Houshold ( ) Single Parent Household ( ) Ethnic Background White ( ) Black or African American ( )

Two or more races ( ) Hispanic or Latino ( ) American Indian or Native Asian ( ) Native Hawaiian or Pacific Islander ( )

<$24,000 ( ) $25,000-$50,000 ( ) $50,000-$80,000 ( ) $81,000 and above ( ) Military Active or Inactive ( )

BOYS & GIRLS CLUB
OF NORTHERN WESTCHESTER

Office Use Only
Pre School (2017-2018) _____
Classroom # _____
Summer Only _____

FEE PAYMENT CONTRACT

Parents Full Name _____ Home # _____

Address _____ Cell # _____

Email Address _____

This contract is made between the Parent/Guardian and The Boys & Girls Club of Northern Westchester.

The Child/Children will be attending Early Childhood Education/Summer Early Childhood Education

Childcare Hours Available 7:30AM - 6:00PM

Childs Last Name _____ First Name _____ Age in Sep '17 _____

Childs Last Name _____ First Name _____ Age in Sep '17 _____

POLICIES

Changes or Withdrawal:

1 The $325 Deposit Non Refundable, $250 off Tuition.

Tuition Payment:

1 Parents/Guardians are Responsible for on Time Tuition Payments. On the 15th of Each Month.
2 Late Fees of $25 will be Charged on the Passed Due Amount.
3 The Boys & Girls Club has the right to remove your Child from the Program if Parent is Deliquent on Payments.

Dismissal:

1 Children Must be Picked Up on Time or a Late Fee will be charged.

	DAYS	HOURS	FEE	NOTES
ECE Hours Requested				
ECE Deposit Received				
ECE Tuition Total				
Financial Aid Award				
Total Payable to the BGC				

Date _____ Signature of Parent/Guardian _____

_____

Betty Lou Ostrye (Childcare Director)

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

LETTER TO HOUSEHOLDS

Dear Parent, Guardian or CACFP Participant:

This center participates in the Child and Adult Care Food Program (CACFP) and serves nutritious meals each operating day. The information requested on the attached Income Eligibility Form for Child Care or Adult Day Care Centers determines how much reimbursement this center will receive from CACFP for these meals and snacks, based on the United States Department of Agriculture (USDA) family income criteria listed below.

We encourage you to complete the form promptly so your center can maximize its reimbursement for healthy meals and snacks. One form needs to be completed for each household every year except for children enrolled in Head Start or At-Risk Only programs. All information on the form will be confidential and used only for the purpose of determining CACFP reimbursement for meals and snacks served at this center.

Foster children are automatically eligible for the highest rate of reimbursement from CACFP. Households with both foster and non-foster children in day care may complete one form, including the foster child as a household member. Eligibility determination for the non-foster children will be based on the information reported on the form by the household.

INCOME ELIGIBILITY GUIDELINES
(Effective July 1, 2016 until June 30, 2017)

HOUSEHOLD SIZE	REDUCED-PRICE MEALS		
	YEAR	MONTH	WEEK
1	21,978	1,832	423
2	29,637	2,470	570
3	37,296	3,108	718
4	44,955	3,747	865
5	52,614	4,385	1,012
6	60,273	5,023	1,160
7	67,951	5,663	1,307
8	75,647	6,304	1,455
FOR EACH ADDITIONAL FAMILY MEMBER	+7,696	+642	+148

SPONSOR/CENTER OFFICIAL _____ SPONSORING ORGANIZATION _____ DATE _____

This institution is an equal opportunity provider.

CACFP
Child and Adult Care Food Program
New York State Department of Health

INCOME ELIGIBILITY FORM
for Child Care Centers

See INSTRUCTIONS on reverse.

CHILD CARE CENTER NAME: _____

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

1. _____ 2. _____ 3. _____

DIRECTIONS:

Complete SECTION A if anyone in your household:

1. Receives Food Stamps
2. Receives Temporary Assistance to Needy Families (TANF)
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR) OR
4. If any of the children enrolled in this child care center are foster children

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

SECTION A

Food Stamp Case Number _____

TANF Number _____

FDPIR Number _____

Names of Foster Children _____

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

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

Signature: _____

Date: _____

FOR SPONSOR USE ONLY

Sponsor Agreement Number _____

Total Household Members _____
(including foster children, if applicable)

Total Income $_____

Free _____ Reduced _____ Paid _____

Date Determined ____ / ____ / ____

Signature of Center Staff _____

SECTION B

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

Name of Household Members	Monthly Gross Income
1. _____	$ _____
2. _____	$ _____
3. _____	$ _____
4. _____	$ _____
5. _____	$ _____
6. _____	$ _____

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

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

Signature: _____

Print Name: _____

SS# XXX-XX-__ __ __ __ Date: _____

Pre School (2017-2018) _____
Classroom # _____
Summer Only _____

BOYS & GIRLS CLUB
OF NORTHERN WESTCHESTER

EMERGENCY INFORMATION

Child Name _____ M ( ) F ( ) D/O/B _____ Allergies _____

Child Name _____ M ( ) F ( ) D/O/B _____ Allergies _____

Parents Full Name _____ E-Mail Address _____

Address _____ Home # _____

_____ Cell # _____

Work # _____

Primary Physicians Name _____ Phone # _____

Primary Dentists Name _____ Phone # _____

Prefered Facility/Hospital _____ _____ Phone # _____

Would You Like Information On Child Health Plus? Yes _____ No _____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____

Cell # _____ Home # _____ Work # _____

Name _____ Relationship _____

Cell # _____ Home # _____ Work # _____

Name _____ Relationship _____

Cell # _____ Home # _____ Work # _____

Name _____ Relationship _____

Cell # _____ Home # _____ Work # _____

AGREEMENTS

Yes ( ) No ( ) I consent to the enrollment of the child(ren) listed above in this facility and have been advised of the policies regarding administration of medications, fees, transportation and the services provided by the facility, and the Office of Children and Family Services regulations un which it operates. I give consent of my child(ren) to take part in neighborhood trips (i.e. library, park and playground) away from the facility under proper Supervision.

Yes ( ) No ( ) In case of accident or injury, I authorize any and all emergency medical, dental and/or surgical care and hospitalization advised by the physicians surgeon or hospital necessary for the proper health and well-being of my child(ren)

Yes ( ) No ( ) I have provided information on my child(ren) special needs (Allergies, Diet, Disabilities, and/or Medical information) to the provider, as may be necessary to assist the facility in properly caring for my child(ren) in case of emergency.

Yes ( ) No ( ) I agree to review and update this information whenever a change occurs and at least every six months.

Children who have special health care needs are those who have chronic physical, developmental, behavioral or emotional conditions expected to last 12 months or more and who also require health and related services of a type beyond that required by children generally. If your child does have special health care needs please discuss these with your child-care provider.

Date _____ Signature of Parent/Guardian _____

BOYS & GIRLS CLUB
OF NORTHERN WESTCHESTER

PRE SCHOOL INTAKE FORM

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

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

PARENT OR GUARDIAN INFORMATION

Parent Name _____ Home Phone # _____

Parent Address _____

Occupation or Place of Employment _____

Cell Phone # _____ Work Phone # _____

Parent Name _____ Home Phone # _____

Parent Address (If Different From Above) _____

Occupation or Place of Employment _____

Cell Phone # _____ Work Phone # _____

FAMILY INFORMATION

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

_____

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

_____

PERSONAL HISTORY

Is the Child Right or Left Handed? R _____ L _____

Has the Child had Previous Group Experience? Yes _____ No _____

If Yes, Where and When? _____

What Words does your Child use for Toileting? _____

Does your Child have any Bowel or Bladder Irregularities? Yes _____ No _____

Does your Child have Tantrums? Yes _____ No _____

Does your Child Suck their Thumb? Yes _____ No _____

Does your Child have any Fears? Yes _____ No _____

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

Yes _____ No _____

Is there any Other Information such as Discipline, Child's Communication, Comforting Etc. That You feel would be Helpful to Us? _____

List any Special Interests you Child has. _____

Are there any Special Food or Eating Instructions? _____

Are there any Special Sleeping or Napping Instructions? _____

What do You Expect your Child to get out of his/her Preschool Experience? _____

_____

_____

_____

_____

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD IN CARE MEDICAL STATEMENT

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

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

Immunizations required for entry into day care ☐ Yes ☐ No

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

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

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

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

Tests

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

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

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

Lead Screening Date: __/__/____

Attach lead level statement

Lead Screening (Include All Dates and Results)

1 year __/__/____ Result: _____ mcg/dL ☐ Venous ☐ Capillary

2 years __/__/____ Result: _____ mcg/dL ☐ Venous ☐ Capillary

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

__/__/____ Result: _____ mcg/dL ☐ Venous ☐ Capillary

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

(Continued on reverse side)