BEVERLY CHILDREN'S LEARNING CENTER

BUILDING FOR THE FUTURE

Out-of-School-Time Program Enrollment Form

Child Information

Child's Name: _____ Date of Birth: _____

Age at Admission: _____ Date of Admission: _____

Child's Home Address: _____

Home Phone Number: _____

Primary Language: _____ Identifying Marks: _____

Eye Color: _____ Hair Color: _____ Skin Color: _____

Sex: _____ Height: _____ Weight: _____

Child's Former Child Care: _____

Parent/Guardian Information

Parent/Guardian Name:_____

Relationship to Child: _____ Marital Status: _____

Home Address: _____

Reachable Phone Number: _____

Email Address: _____

Business Name: _____

Business Address: _____

Business Phone Number: _____ Hours at Work: _____

Parent/Guardian Name:_____

Relationship to Child: _____ Marital Status: _____

Home Address: _____

Reachable Phone Number: _____

Email Address: _____

Business Name: _____

Business Address: _____

Business Phone Number: _____ Hours at Work: _____

Child's Schedule (Limit: 10 hours daily)

Monday	Tuesday	Wednesday	Thursday	Friday
_____	_____	_____	_____	_____

Additional Information

Child's Physician: _____

Address: _____ Phone Number: _____

Allergies/Special Diets: _____

Individual Health Plan for child with a chronic health condition? If yes, please attach._____

Copies of any custody agreements, court orders, and restraining orders pertaining to the child? If yes, please attach. Yes____ No____

Special limitations or concerns: _____

_____

School Age Only

Current School: _____

School Address: _____ School Phone Number: _____

I certify that documentation of physical examination and immunizations in accordance with public school health requirements and lead poisoning screening in accordance with public health requirements are on file at my child's school.

_____ _____

Parent/Guardian Signature **Date**

FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM

Child's Name: _____ Date of Birth: _____

I authorize staff in the child care program who are trained in the basics of first aid/CPR to give my child first aid/CPR when appropriate.

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical care facility and/or to _____, and to secure necessary medical treatment for my child.

Child's Physician Name: _____
Address: _____
Phone Number: _____

Child's Allergies: _____
Chronic Health Conditions: _____

Emergency Contacts (*In order to be contacted*)
Name_____
Address_____
Relationship to child_____
Home Phone_____ Cell Phone_____
Do you give permission for child to be released to this person? Yes_____ No_____

Name_____
Address_____
Relationship to child_____
Home Phone_____ Cell Phone_____
Do you give permission for child to be released to this person? Yes_____ No_____

Name_____
Address_____
Relationship to child_____
Home Phone_____ Cell Phone_____
Do you give permission for child to be released to this person? Yes_____ No___

Health Insurance Coverage_____ Policy #_____

Parent/Guardian Name: _____ Phone_____ Cell_____

Parent/Guardian Name: _____ Phone_____ Cell_____

_____ _____
Parent /Guardian Signature Date (valid for one year)

Transportation Plan and Authorization

CHILD'S NAME: _____

Parent/Guardian Name(s): _____ _____

Home Address: _____

Contact Phone Number(s):

(Home) _____ **(Cell)**_____**(Work)**_____

MY CHILD WILL ARRIVE AT THE PROGRAM:

___PARENT DROP OFF

___SUPERVISED WALK

___UNSUPERVISED WALK

___PUBLIC/PRIVATE/VAN

___PROGRAM BUS/VAN

___CONTRACT/VAN

___PRIVATE TRANS. ARRANGED BY PARENT

___OTHER

MY CHILD WILL DEPART FROM THE PROGRAM:

___PARENT PICK UP

___SUPERVISED WALK

___UNSUPERVISED WALK

___PUBLIC/PRIVATE/VAN

___PROGRAM BUS/VAN

___CONTRACT/VAN

___PRIVATE TRANS. ARRANGED BY PARENT

___OTHER

VEHICLE/FACILITY RELEASE AUTHORIZATION

I authorize the release of my child (from agency vehicles or facilities) to the following people with the understanding that they must be at least 13 years of age and be willing to present positive identification to agency personnel upon request.

Name	Relationship to Child	Telephone Number

I understand that my child will not be released to any individual not listed above, unless I have made prior arrangements with the agency in writing.

Parent/Guardian Signature:_____ Date_____

General Consents	Parent/ Guardian Initials
I authorize (BCLC) to discuss the status and/or progress of my child with other agencies and/or persons in order to share information which may be considered of value in the care and service of my child. I understand that such information will be kept confidential as a part of my child's file. I also understand that I have the right to terminate consent at any time. Please note, however, that the BCLC employees are mandated by law to report any possible cases of abuse and neglect of your child to the Massachusetts Department of Children and Families.	
I authorize BCLC to photograph, audio/or videotape my child while in attendance at the agency. I further authorize the release of such materials for public relations, advertising, and social media as the agency deems appropriate. I understand that BCLC will not conduct any research or experimentation involving my child without my formal consent in written form, but that my child may, during the normal operation of the agency, be observed by people such as student teachers, their supervisors or other human service professionals.	
I authorize BCLC to take my child on field trips (i.e. Beverly Public Library, Dane Street Beach, Lynch Park, and Beverly School for the Deaf and St. Peter's gymnasium), either on foot or in an authorized vehicle, under the supervision of designated agency personnel. I understand that separate permission forms for certain trips will also be required. In addition, I understand that my child can possibly be excluded from attending a field trip if their behavior is unsafe or inappropriate, which could, in any way, prevent the staff from effectively and attentively caring for all of the children.	
I understand that failure to take full responsibility for my child after the 6pm closing time in the center based program and after the 5pm closing time in the Family Child Care programs, will result in the assessment of a $1.00 per child per minute "late fee" and that such a charge will be due immediately when my child is released. I further understand that such negligence may be considered a form of neglect and may be reported as such, and that frequent instances of tardiness may jeopardize my child's enrollment status.	
I authorize the staff of BCLC to apply SPF 30 or higher sunscreen on my 6month or older child as needed. Alternative methods for children younger than 6months will be utilized. I understand that if I wish my child to use a certain brand, I am responsible for supplying it in the original bottle labeled with my child's name.	
I authorize the staff of BCLC to apply insect repellent containing DEET on my child on a maximum basis of once daily as needed. I understand that if I wish my child to use a certain brand, I am responsible for supplying it in the original bottle labeled with my child's name.	

Parent/Guardian Signature_____ Date_____

Authorization for the Release of Information and Records

In order for the Beverly Children's Learning Center (BCLC) to provide quality service to our families, we request the right to coordinate our services with other agencies or programs who have had past or present involvement with your child or family. Signing the statement below enables BCLC to send and receive reports to discuss your child's developmental status and/or progress, and you or your child's situation with only the specific agency/school named on this form. I understand that I am signing this release of my own free will, and that I have the right to terminate this release of information at any time, without affecting my child's child care.

THE RELEASE OF INFORMATION AND TERMINATION MAY BE RELEASED TO THE AGENCY BELOW:

I hereby give permission to BCLC to request information from, or release information to:

Agency/Program: _____

Town: _____

Signed: _____ Date: ___/_____/_____

SIGN BELOW ONLY IF YOU CHOOSE NOT TO RELEASE INFORMATION TO/OR FROM BCLC. :

I (parent or legal guardian) decline to have information released to or from BCLC. I understand that refusing to allow communication may interfere with BCLC'S ability to provide my child with the highest level of communication.

Signed: _____ Date: _____/_____/___

Please Note: All information provided from agencies/programs that are involved with your child will remain confidential. BCLC cannot withhold such information if it is determined to be at risk to your child or family.

Beverly Children's Learning Center

Internet Use – Permission Form

Child's Name: _____

Due to recommendations made by the Department of Early Education and Care, we are asking you to agree to or deny your child to have internet access while at Beverly Children's Learning Center. Please put a check next to the appropriate line, and then indicate any specific restrictions that you may want them to have.

_____ I want my child to have internet access

_____ I **DO NOT** want my child to have internet access

Restrictions: _____

_____

Parent/Legal Guardian: _____ Date: _____

Beverly Children's Learning Center (BCLC) is committed to ensuring that all children with special needs have access to appropriate, high quality educational experiences, and that their parents/legal guardians are provided with information of the additional service options available on site or through local affiliations.

This checklist has been developed to assist in the process of your child's integration within BCLC's Program.

Does your child have a current IEP or ISP? _____ Yes _____ No

Has your child previously had an IEP or ISP? _____ Yes _____ No

Has your child been diagnosed with or recommended for an evaluation for any of the following?

(Please place a check mark next to all that apply to your child)

_____ Attention Deficit Disorder
_____ Autism
_____ Asperger's Syndrome
_____ Behavior Disorder
_____ Cerebral Palsy
_____Developmental Delay
_____ Diabetes
_____ Downs Syndrome
_____ Eating Disorder
_____ Emotional Disorder or Trauma (PTSD)
_____ Hearing Impairment
_____ Intellectual Impairment
_____ Language Impairment
_____ Learning Disability
_____ Medically Fragile
_____Pervasive Developmental Disorder (PDD)
_____ Perceptually Handicapped
_____ Specific Learning Disability
_____Speech or Language Impairment
_____Tourette Syndrome
_____Traumatic Brain Injury
_____ Visual Impairment
_____ Other: _____

Does your child currently receive any of the following services? Or, would you like BCLC to help you locate these services for your child? (Please indicate by placing a check mark in the appropriate column.)

Additional Services	Currently Receive	Need Assistance to Locate
Speech/Language Therapy		
Audiology Services		
Psychological Services		
Occupational Therapy		
Counseling Therapy		
Mobility Services		
Social Work Intervention		
Family Counseling		
Remedial Academic Program		
Physical Therapy		
Visual Services		
Social Skills Program		
Early Intervention		
Nutritionist Services		
Other:		

Is there any additional information that you would like us to know about your child or family that would be beneficial to this placement? _____

_____

_____

Thank you for taking your time to complete this checklist. BCLC does not discriminate against special needs students who seek admission to its programs. BCLC enrolls each individual student on a case by case basis and reserves the right to accept or maintain only those students for whom we can ensure a successful inclusionary experience in BCLC's Program. Students who pose a significant health or safety risk to themselves or others may meet the criteria for admission into a more specialized program than we can offer.

Signature: _____ Date: _____

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 1. All Household Members

Name of Enrolled Child(ren):

Names of all household members (First, Middle Initial, Last)	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.	CHECK IF NO INCOME
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Part 2. Benefits: If any member of your household received SNAP or TAFDC cash assistance, provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME:_____ CASE NUMBER: _____

Part 3. If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call the Child Care Sponsor at Phone #: Homeless ☐ Migrant ☐ Runaway☐

Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List **only** household members with income)	**B. Gross income and how often it was received** 1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) *Jane Smith*	$200/weekly	$150/twice a month	$100/monthly	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Last four digits of Social Security Number: _ _ _ - _ _ - _____ ☐ I do not have a Social Security Number

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
❑ Hispanic or Latino	❑ Asian	❑ American Indian or Alaska Native
❑ Not Hispanic or Latino	❑ White	❑ Native Hawaiian or Other Pacific Islander
	❑ Black or African American	

Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year Household size: _____

Categorical Eligibility: ___ Eligibility: Free___ Reduced___ Denied___

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.

Effective July 1, 2016 to June 30, 2017	
Household size	**Yearly**
1	21,978
2	29,637
3	37,296
4	44,955
5	52,614
6	60,273
7	67,951
8	75,647
Each additional person:	+ 7,696

Privacy Act Statement: 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 the participant 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 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 for the participant or other (FDPIR) identifier 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 the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: 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: http://www.ascr.usda.gov/complaint_filing_cust.html, 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.

Please return this page on your child's first day of care.

Handbook Acknowledgement

I have read, understand and will adhere to the policies and procedures in this handbook for parents and guardians.
Parent/Guardian Signature: Date: