



**Computer Kids
ENROLLMENT APPLICATION**

Please give 2 weeks notice if child will no longer attend program

Desired Start Date: _____

Actual Start Date: _____

Child's Name: _____

_____ **Birthdate:** _____

Parent(s)/Legal Guardian's Info

Name Relationship Birth date

Name Relationship Birth date

Home Address _____
Street City/State Zip Code

Home Phone: () _____ - _____ **Cell Phone:** () _____ - _____


Work: () _____ - _____ **Alt. Phone:** () _____ - _____

Name of Employer/School/Training Program: _____

Address: _____
Street City/State Zip Code

Scheduling

Day/s & Hours of Care:

	Monday	Tuesday	Wednesday	Thursday	Friday
Drop Off					
Pick Up					

(Please circle answers that apply to your child)

Is your child a school aged student? Yes / No If Yes, please indicate:

School/Address _____

Phone: () _____ - _____ Room # _____ Teacher _____

My child needs (circle needs) Child Care Kindergarten
Before Care ONLY After Care ONLY Before AND After Care

Funding Information

Private Pay Weekly Fee \$ _____
 CCIS Weekly Co-Pay \$ _____
 Family Record # _____ - _____
 Case Worker _____
 District Office _____
 District Phone () _____ - _____ Fax () _____ - _____

Person Responsible for Fee Payments: _____
Parent Signature _____

Phone: _____
Date _____

PLEASE NOTE, ADMISSIONS TO OUR PROGRAM SHALL BE MADE WITHOUT REGARD TO RACE, COLOR, RELIGIOUS CREED, DISABILITY, ANCESTRY, NATIONAL ORIGIN (INCLUDING THOSE WITH LIMITED ENGLISH PROFICIENCY), AGE OR SEX. PROGRAM SERVICES SHALL BE MADE ACCESSIBLE TO PERSONS WITH DISABILITIES THROUGH MOST PRACTICAL METHODS AVAILABLE.

Getting to Know Your Family **INTAKE FORM**

Date: _____

Child's Name: _____
Mother's Name: _____ Father's Name: _____

Tell Us About Your Child and Family

1. What do you feel are your child's unique gifts, strengths, and talents?

2. What are your child's favorite games/toys/activities?

3. Favorite likes and dislikes? _____

4. Fears? _____

5. What are Your families expectations of our program?

6. Has your child been in an early learning program/child care before? Yes / No

If so.... from _____ to _____ Where? _____

If you don't mind sharing, what was your reason for leaving? _____

7. Are there custody issues that we should discuss? Yes / No

8. Does your child have any siblings? Yes / No If yes, what are their names? _____

9. Does your family have any pets? Yes / No If yes, what is/are their name/s?

10. What nicknames might your child respond to? _____

11. a. Are there any special needs (Medical, Developmental, Social, Mental Health, etc.) your child has been observed or is receiving treatment for? Yes / No If Yes, please explain _____

If No, please skip to QUESTION 12.

b. If Yes, does your child have an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP)? Yes / No (If Yes, please bring us a copy of the plan so we can provide the best possible learning experience for your child.)

c. What services/program/individuals are working with your child to meet your child and family's needs? _____

d. Would you be willing to sign a release of information for this program to may speak with us about what we can do to provide additional support for your child while in our care? Yes / No

12. Does your child have any allergies? Yes / No If Yes, please specify:

Food: _____

Seasonal/Environmental: _____

Medicine: _____

13. Describe your child's schedule at home:

Morning Wake up Time: _____

Bed Time: _____

Nap Time & Duration: _____

Meal Time: _____

14. Toilet Use: My child..... (Please Circle the one that best describes your child)

*Uses the toilet on his/her own *without help*

*Uses the toilet on his/her own but *needs help*

*Beginning to use the toilet and *still wears pampers*

*uses pampers *only*

15. Is any part of our educational program especially important to your child/family? _____

16. Is there any information about your family's culture, ethnicity, language, or religion that is important for us to know? _____

17. Would you and/or your family like to be a resource for any cultural awareness activities? Yes / No

18. Are you willing to: Volunteer in our classrooms? Yes / No Attend field trips? Yes / No

Participate in center activities and events? Yes / No

19. What would you most like to see happen for your child while he/she attends our center? _____

20. Is there anything else that you would like to share with us? _____

Thank You for helping Us get to know Your Child and Family!
Computer Kidz Day Care Inc.

Computer Kidz Learning Center Child Care Agreement Form

Congratulations on your decision to enroll your child/ren into our exciting learning center where we are “preparing little wonders everyday”! Below, you will find our policies which have been put in place in order to assure that we provide your child/ren with the utmost quality care.

HOLIDAYS & IN-SERVICE

INITIALS _____

Computer Kidz is closed the following holidays: New Years Day, Martin Luther King’s Birthday, Memorial Day, Independence Day, Labor Day, Thanksgiving and Black Friday, Christmas Day. Please note: we reserve the right to revise the list of closed days. In order to ensure that our employees are equipped to provide a safe and stimulating learning environment for our students, designated days will be reserved for In-Service so that staff is able to receive additional training. You will be notified of those days at least 30 days in advance.

SECURITY

INITIALS _____

For security reasons, parents are required to Clock In and Clock Out your child upon arrival and departure each day. You must accompany your child to their designated classroom. Children may NEVER be left unsupervised in the center when dropping them off or picking them up. Children are only released to their parents, individuals who are written on the Emergency Contact Form, or those who are listed in our electronic security system.

SICK POLICY

INITIALS _____

Our goal is to prevent children from getting sick. Therefore, parents will be notified and required to pick up their child if they exhibit any of the following symptoms:

- Fever of 101.5 or higher
- Vomiting
- Excessive Diarrhea
- Symptoms of contagious illness conditions, unexplained rashes and/or any other illnesses
- Symptoms of illness which preclude the child from participation of daily activity

EMERGENCY CONTACTS

INITIALS _____

Parents must provide current telephone information where they can be reached during the time their child is in care. At least one alternative contact is required as well. This information must be updated every 6 months. Parents must notify a director as soon as possible whenever there is a change.

HEALTH ASSESSMENT

INITIALS _____

A physician’s health assessment must be completed within 30 days of your child’s start date and again for:

- | | |
|---------------|------------------------------|
| Infants | 2, 4, 6, 9, and 12 months |
| Toddlers | 15, 18, and 24 months |
| Preschoolers+ | Every year on their birthday |

TERMINATION POLICY

INITIALS _____

You must give the Center Director a minimum of 2 weeks’ notice of your intent to withdraw your child from Computer Kidz Learning Center for any reason other than funding termination. Failure to do so will result in the being charged an additional 2 weeks.

HOURS OF OPERATION

INITIALS _____

We have various learning centers. The hours of operation for this locations is _____ am to _____ pm.
Please initial that we have informed you of hours of operation.

LATE ARRIVAL FOR PICKING UP CHILD

INITIALS _____

If you are late picking up your child, you will incur a late fee. There is a \$10.00 late fee for the first fifteen minutes and a one dollar late fee for each minute thereafter. Late fees are due on the same day or your child may not be able to return to school on the next day. Computer Kidz reserves the right to terminate services for continuous late payments of tuition and/or late fees.

BOOK FEES AND REGISTRATION FEES

INITIALS _____

Initial that the center director has discussed book fees and registration fees. A registration fee of [] is due and book fee of [] is due. Note: Book fees due for Kindergarten students.

SERVICE PROVIDED:

INITIALS _____

Computer Kidz will provide meals and childcare service to my child(ren). Computer Kidz reserve the right to terminate our service due to disruptive or inappropriate behavior of child or parent.

PARTICIPATION OF ACTIVITIES & EVENTS AT C.K.L.C.

INITIALS _____

FUND RAISERS

INITIALS _____

Parent agrees to participate in the center's funding raisers which result in the purchase of supplies and equipment.

TUITION, FEES, AND LATE FEES

INITIALS _____

Tuition and/or copayments are due on Friday for the upcoming week. There is a \$10.00 late fee for late payments. Computer Kidz reserves the right to void this contract agreement for failure to pay timely tuition and fees. Client agrees to the information checked below. All clients MUST give a notice 2 weeks in advance of Withdrawal of services or those days will be invoiced as if attended.

RECEIVED NOTICE OF ITEMS NEEDED FOR MY CHILD.

INITIALS _____

- Private Pay
- CCIS

Weekly Fee \$ _____
 Weekly Co-Pay\$ _____
 Family Record # ____ - _____
 Case Worker _____
 District Office _____
 District Phone () ____ - _____ Fax() ____ - _____

Person Responsible for Fee Payments: _____

Phone: _____

Parent Signature _____

Date _____

Revised 8/201

***-ITEMS YOUR CHILD OR CHILDREN WILL NEED FOR CHILDCARE
-ALL ITEMS MUST BE LABELLED WITH PERMANENT MARKER***

___ DIAPERS OR PULL UPS

___ WIPES AND TISSUES

___ SHEET AND BLANKET (TAKE HOME EVERY FRIDAY FOR CLEANING AND RETURN ON MON MORNING)

___ TWO EXTRA SETS OF CLOTHINGS (PUT IN GALLON SIZE SIP LOCK BAG)

___ PACIFIER IF APPLICABLE

___ BOTTLE/SIPPY CUPS IF APPLICABLE

___ SMOCK OR LARGE SHIRT TO COVER CLOTHES DURING PAINTING

___ HOMEWORK COMPOSITION BOOK FOR PRESCHOOLERS ONLY

___ BOX OF CRAYONS – PRESCHOOLERS ONLY

___ BOX OF MARKERS – PRESCHOOLERS ONLY

I grant COMPUTER KIDS Daycare INC. permission to photograph my child during observations, class projects, field trips, or any other classroom activity. PHOTOS may be used in the center's portfolios, computer kids website or displayed within the center.

Date: _____

Child(ren) Name (please print)

Parent's signature:

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:
<input type="checkbox"/> I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.		
PARENT'S SIGNATURE:		

DO NOT OMIT ANY INFORMATION
 This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
 NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
 NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
 NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
 NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
 YES NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG) <input type="checkbox"/> YES <input type="checkbox"/> NO	NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.						
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">VISION (subjective until age 3)</td> <td></td> </tr> <tr> <td>HEARING (subjective until age 4)</td> <td></td> </tr> <tr> <td>LEAD</td> <td></td> </tr> </table>	VISION (subjective until age 3)		HEARING (subjective until age 4)		LEAD	
VISION (subjective until age 3)							
HEARING (subjective until age 4)							
LEAD							

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:	SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:	TITLE:
PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.

EMERGENCY CONTACT PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270.124(a)(b), 3270.181 & 182, 3280.124(a)(b), 3280.181 & 182, 3290.124(a)(b), 3290.181 & 182

CHILD'S NAME		BIRTH DATE
ADDRESS		
MOTHER'S NAME/LEGAL GUARDIAN		HOME TELEPHONE NUMBER
E-MAIL ADDRESS		MOBILE TELEPHONE NUMBER
ADDRESS		
BUSINESS NAME		BUSINESS TELEPHONE NUMBER
ADDRESS		
FATHER'S NAME/LEGAL GUARDIAN		HOME TELEPHONE NUMBER
E-MAIL ADDRESS		MOBILE TELEPHONE NUMBER
ADDRESS		
BUSINESS NAME		BUSINESS TELEPHONE NUMBER
ADDRESS		
EMERGENCY CONTACT PERSON(S)	NAME	TELEPHONE NUMBER WHEN CHILD IS IN CARE
PERSON(S) TO WHOM CHILD MAY BE RELEASED	NAME	ADDRESS
		TELEPHONE NUMBER WHEN CHILD IS IN CARE
NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER		TELEPHONE NUMBER
ADDRESS		
SPECIAL DISABILITIES (IF ANY)	ALLERGIES (INCLUDING MEDICATION REACTIONS)	
MEDICAL OR DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION	MEDICATION, SPECIAL CONDITIONS	
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD		
HEALTH INSURANCE COVERAGE FOR CHILD OR MEDICAL ASSISTANCE BENEFITS	POLICY NUMBER (REQUIRED)	
PARENTS SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT		
OBTAINING EMERGENCY MEDICAL CARE	ADMIN. OF MINOR FIRST - AID PROCEDURES	
WALKS AND TRIPS	SWIMMING	
TRANSPORTATION BY THE FACILITY	WADING	

PERIODIC REVIEW

SIGNATURE OF PARENT OR GUARDIAN

DATE

SIGNATURE OF PARENT OR GUARDIAN

DATE

**Child and Adult Care Food Program
Child Enrollment Form (Sample)**

Sponsor: _____
Center: _____

ENROLLMENT FORM FOR CHILDREN IN CHILD CARE (SAMPLE)

This document does not have to be completed for children in Emergency Shelters, Outside School Hours, and/or At-Risk programs. It is recommended to have new CACFP Annual Enrollment Forms completed each year during the Household Eligibility Application renewal period. Review completed enrollment form and enter the effective date in lower right hand section.

PARENTS: This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents and guardians to complete a CACFP Annual Enrollment Form when enrolling their child(ren) and again every year thereafter. This information will help ensure all children receive appropriate meals during their care.

Please complete all areas to include signing and dating same.

FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	DAYS OF WEEK IN ATTENDANCE	TIMES CHILD NORMALLY ATTENDS DURING WEEK								MEALS RECEIVED
		TIME-IN			TIME OUT			TIME CHILD ATTENDS SCHOOL		
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
FIRST CHILD	<input type="checkbox"/> MONDAY <input type="checkbox"/> TUESDAY <input type="checkbox"/> WEDNESDAY <input type="checkbox"/> THURSDAY <input type="checkbox"/> FRIDAY <input type="checkbox"/> SATURDAY <input type="checkbox"/> SUNDAY									<input type="checkbox"/> BREAKFAST <input type="checkbox"/> A.M. SNACK <input type="checkbox"/> LUNCH <input type="checkbox"/> P.M. SNACK <input type="checkbox"/> SUPPER <input type="checkbox"/> EVENING SNACK
NAME		<input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours								
BIRTH DATE		Other:								
AGE		Enrollment Date:				Withdrawal Date:				
SECOND CHILD	<input type="checkbox"/> Same as Above <input type="checkbox"/> MONDAY <input type="checkbox"/> TUESDAY <input type="checkbox"/> WEDNESDAY <input type="checkbox"/> THURSDAY <input type="checkbox"/> FRIDAY <input type="checkbox"/> SATURDAY <input type="checkbox"/> SUNDAY									<input type="checkbox"/> Same Meals as Above <input type="checkbox"/> BREAKFAST <input type="checkbox"/> A.M. SNACK <input type="checkbox"/> LUNCH <input type="checkbox"/> P.M. SNACK <input type="checkbox"/> SUPPER <input type="checkbox"/> EVENING SNACK
NAME		<input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours								
BIRTH DATE		Other:								
AGE		Enrollment Date:				Withdrawal Date:				
THIRD CHILD	<input type="checkbox"/> Same as Above <input type="checkbox"/> MONDAY <input type="checkbox"/> TUESDAY <input type="checkbox"/> WEDNESDAY <input type="checkbox"/> THURSDAY <input type="checkbox"/> FRIDAY <input type="checkbox"/> SATURDAY <input type="checkbox"/> SUNDAY									<input type="checkbox"/> Same Meals as Above <input type="checkbox"/> BREAKFAST <input type="checkbox"/> A.M. SNACK <input type="checkbox"/> LUNCH <input type="checkbox"/> P.M. SNACK <input type="checkbox"/> SUPPER <input type="checkbox"/> EVENING SNACK
NAME		<input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours								
BIRTH DATE		Other:								
AGE		Enrollment Date:				Withdrawal Date:				
FOURTH CHILD	<input type="checkbox"/> Same as Above <input type="checkbox"/> MONDAY <input type="checkbox"/> TUESDAY <input type="checkbox"/> WEDNESDAY <input type="checkbox"/> THURSDAY <input type="checkbox"/> FRIDAY <input type="checkbox"/> SATURDAY <input type="checkbox"/> SUNDAY									<input type="checkbox"/> Same Meals as Above <input type="checkbox"/> BREAKFAST <input type="checkbox"/> A.M. SNACK <input type="checkbox"/> LUNCH <input type="checkbox"/> P.M. SNACK <input type="checkbox"/> SUPPER <input type="checkbox"/> EVENING SNACK
NAME		<input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours								
BIRTH DATE		Other:								
AGE		Enrollment Date:				Withdrawal Date:				
FIFTH CHILD	<input type="checkbox"/> Same as Above <input type="checkbox"/> MONDAY <input type="checkbox"/> TUESDAY <input type="checkbox"/> WEDNESDAY <input type="checkbox"/> THURSDAY <input type="checkbox"/> FRIDAY <input type="checkbox"/> SATURDAY <input type="checkbox"/> SUNDAY									<input type="checkbox"/> Same Meals as Above <input type="checkbox"/> BREAKFAST <input type="checkbox"/> A.M. SNACK <input type="checkbox"/> LUNCH <input type="checkbox"/> P.M. SNACK <input type="checkbox"/> SUPPER <input type="checkbox"/> EVENING SNACK
NAME		<input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours								
BIRTH DATE		Other:								
AGE		Enrollment Date:				Withdrawal Date:				

Signature

Signature of Parent or Guardian

Date

Telephone Number of Parent or Guardian

CHILD CARE REPRESENTATIVE USE ONLY:

Name of Representative/Signature

Date

The effective date can be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month this form is received.

This portion of the form can be used to capture multi-year annual updates.

Annual Time Period Covered by Signature: _____ to _____

Signature Parent/Guardian _____ **Date** _____

Signature Center Administrator/Home Provider _____ **Date** _____

Annual Time Period Covered by Signature: _____ to _____

Signature Parent/Guardian _____ **Date** _____

Signature Center Administrator/Home Provider _____ **Date** _____

Annual Time Period Covered by Signature: _____ to _____

Signature Parent/Guardian _____ **Date** _____

Signature Center Administrator/Home Provider _____ **Date** _____

Annual Time Period Covered by Signature: _____ to _____

Signature Parent/Guardian _____ **Date** _____

Signature Center Administrator/Home Provider _____ **Date** _____

The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800)877-8339; or (800) 845-6136 (Spanish).

USDA is an equal opportunity provider and employer.