The Center: A Drop-In Community Learning and Resource Center, Inc.

Enrollment Application *Revised 5.13.2024*

Application fees: $50 (non-refundable)

(1) Program Selection

☐ Before Care Program (7:00AM-9:00AM)	☐ Early Childhood Education Program (8:00AM-3:00PM) 4 &5 years
☐ After School Enrichment Program (K-5th grades)	☐ Summer Enrichment Program (K-5th grades)
☐ After School Enrichment Program (Middle School)	☐ Summer Enrichment Program (Middle School grades)

(2) Child Information

Child's Name: _____ **Date of Birth:** _____ **Age:** _____ **Gender:** ☐ **Male** ☐ **Female**

Address: _____ **Apt.#**_____

City/State: _____ **Zip:** _____ **Home Phone:** ( ) _____

Child's School Name: _____ **Child's grade (current):** _____

Please select a "Race" and answer yes or no under Hispanic/Latino and if you answer yes; please provide your child's Ethnicity/Country of Origin.

"Race Categories"	Hispanic or Latino		Ethnicity/Country of Origin
☐ White	☐ NO	☐ YES-	_____
☐ Black /African American	☐ NO	☐ YES-	_____
☐ Asian	☐ NO	☐ YES-	_____
☐ American Indian/Alaskan Native	☐ NO	☐ YES-	_____
☐ Native Hawaiian/ Other Pacific Islander	☐ NO	☐ YES-	_____
☐ Asian & White	☐ NO	☐ YES-	_____
☐ Black/African American & White	☐ NO	☐ YES-	_____
☐ American Indian/Alaskan Native & White	☐ NO	☐ YES-	_____
☐ American Indian/Alaskan Native & Black African American	☐ NO	☐ YES-	_____
☐ Other Multi Racial: _____	☐ NO	☐ YES-	_____

(3) Child's Medical History

Does your child have any of the following medical problems or concerns? Please check all boxes that apply.
(This information is used to ensure your child's well being and <u>will not</u> affect your child's acceptance)

- ☐ **Asthma**
- ☐ **Glasses**
- ☐ **Hearing aid needed**
- ☐ **Frequent Bloody Nose**
- ☐ **Epi-Pen use**
- ☐ **ADD or ADHD (Hyperactivity)**
  Medication _____
- ☐ **Allergic reactions to:**
  _____
- ☐ **Other serious medical conditions**
  Please explain: _____
  _____
  _____
  _____
- ☐ **Learning Disabilities**
  Type_____
- ☐ **Special education at school**
  Does your child have an I.E.P.? ☐ Yes ☐ No
  (If you answered yes, please provide a copy of the plan to the Center.)
- ☐ **504 Plan**

Physician Name _____ Physician Phone Number _____

Physician Address_____ City/State/Zip _____

Dentist Name _____ Dentist Phone Number _____

Dentist Address_____ City/State/Zip _____

(4) Guardian Information

Is this child a ward of the state? ☐ YES ☐ NO Social Worker's Name: _____ Phone Number: _____

Guardian Name: _____ Relationship to child: _____

Address (if different than child's): _____ City/State _____ Zip Code _____

Employer Name: _____

Home Phone: _____ Work Phone: _____ Work Extension: _____

Cell/Pager: _____ Email: _____

Guardian Name: _____ Relationship to child: _____

Address (if different than child's): _____ City/State _____ Zip Code _____

Employer Name: _____

Home Phone: _____ Work Phone: _____ Work Extension: _____

Cell/Pager: _____ Email: _____

(5) Emergency Contact Information

(Two contacts other than the legal guardians are required.)

(1) Primary emergency contact and pick-up name (*cannot be guardian*): _____

Relationship to child: _____ Home Address: _____

Home Phone: _____ Work Phone: _____ Cell/Pager: _____

(2) Secondary emergency contact and pick-up name (*cannot be guardian*): _____

Relationship to child: _____ Home Address: _____

Home Phone: _____ Work Phone: _____ Cell/Pager: _____

(6) Financial Statement

Financial Assistance Received *(Check all that apply):*

☐ TANF ☐ Food Stamps ☐ General Assistance ☐ Social Security Disability ☐ Social Security Income
☐ Veterans Compensation ☐ Care 4 Kids ☐ Alimony

Please write your income and family size below and submit three current payroll checks with your application.

Family Size	Weekly Income	Bi-Weekly Income	Annual Income

(7) General Release

Child First Name: _____ **Child Last Name:** _____

I, _____, the legal guardian of _____
(Print Legal Guardian's Name) **(Print Child's Name)**

Hereby release *The Center: A Drop-In Community Learning & Resource Center program*, and any organization with which it might contract for services, from any and all liability for any injury that might befall my child during *The Center: A Drop-In Community Learning & Resource Center* programs and activities. I understand that this program is educational and recreational and I hereby certify my child is in good health and may participate in all aspects of program activities except as stated in writing and included on this form.

I give permission for my child to participate in:

- The childcare provider, has my permission to transport my child, if necessary, when my child is in care.
- Field trips either walking, in the van or bus.
- Computer classes and I will review the Parent Handbook policies and procedures and discuss the policies and the acceptable use of the computer and internet with my child/children.

I authorize the New London Public School District to give any and all medical and/or educational records concerning my child to *The Center: A Drop-In Community Learning & Resource Center*. I understand that this information will be used to meet state health requirements and to evaluate the academic and fitness needs and performance of my child. I further give consent to *The Center: A Drop-In Community Learning Center* to assess the impact of programming on my child's academic progress and social development through research and use of evidence based practices.

I authorize *The Center: A Drop-In Community Learning & Resource Center* the right to use photographs and other records of my child's likeness, voice, and sounds during his/her participation, and to reuse or license the right to reuse such photographs and recordings of his/her name, likeness and biography, in all media and in all forms, including, but not limited to, his/her participation in programs and activities, without compensation to me or any limitation whatsoever.

Behavior Management- We promote a positive system of behavior management based on praise, humor, modeling, redirection, and choice. If a child does not respond to these strategies, the staff member will issue a verbal warning. If the behavior continues, issue a second warning and indicate the consequences if the behavior continues. After the second warning staff may:

- Initiate a time-out for a period of time that is age-appropriate (number of minutes not to exceed the age of the child)
- Limit participation in activities
- Revoke privileges
- Contact the parent

The following behaviors will not be tolerated: fighting, stealing, vandalism, intimidation, extortion, and defiance. Consequences for such behavior may include:

- Suspension from the program
- Reparation of damages
- Dismissal from the program
- Log any intervention in the participant's file.
- Following any disciplinary intervention, ask the child to identify the behavior that warranted the intervention as well as appropriate behaviors to use next time.

Methods of Discipline:

- Children will be encouraged to think of solutions or alternatives for their own misbehavior. This enables the child to accept responsibility for their own actions.
- Children will be redirected from aimless, inappropriate behavior to a more constructive, successful experience by using appropriate choices.
- Children will be removed from a provoking situation. This technique gives children the opportunity to gain control of him/her self. If the child becomes out of control and/or poses a danger to him/her self or other children, he will be sent to the Head Teacher or the Executive Director. The objective is to preserve the child's self-esteem, not to exploit or demean the child. The child decides how long he/she needs before returning to the group.

I authorize *The Center: A Drop-In Community Learning & Resource Center*, to have any and all necessary medical care provided to my child in case of an emergency. I understand that I will be contacted as soon as possible, should such emergency arise.

Guardian's Signature _____ **Date:** _____

Annual Review of Application

Date that the application was reviewed: _____. Guardian's Signature_____

Date that the application was reviewed: _____. Guardian's Signature_____

Date that the application was reviewed: _____. Guardian's Signature_____

If you need to update any information on this application please request for a change of information form.

Do not write below * OFFICE USE ONLY * Do not write below

Supplemental Information Checklist

	Date Received	Staff Initials	Comments
☐ $50 Application Fee			
☐ Nutrition Form			
☐ Care 4 Kids Application			
☐ Current Paychecks			
☐ Student Health Records			
☐ Birth Certificate (ECEP Only)			
☐ Potassium Iodide Authorization Form			
☐ Release Forms			

State of Connecticut Department of Education
Health Assessment Record

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part 1) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part 2) and the oral assessment (Part 3).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, licensed pursuant to chapter 378, a physician assistant, licensed pursuant to chapter 370, a school medical advisor, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

Please print

Student Name (Last, First, Middle)	Birth Date	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity	❑ Black, not of Hispanic origin
	❑ American Indian/ Alaskan Native	❑ White, not of Hispanic origin
Primary Care Provider		❑ Asian/Pacific Islander
	❑ Hispanic/Latino	❑ Other
Health Insurance Company/Number* or Medicaid/Number*		
Does your child have health insurance? Y N Does your child have dental insurance? Y N	If your child does not have health insurance, call **1-877-CT-HUSKY**	

* If applicable

Part 1 — 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	Hospitalization or Emergency Room visit	Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocations	Y	N	Fainting or blacking out	Y	N
Allergies to medication	Y	N	Any muscle or joint injuries	Y	N	Chest pain	Y	N
Any other allergies	Y	N	Any neck or back injuries	Y	N	Heart problems	Y	N
Any daily medications	Y	N	Problems running	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	N	Bleeding more than expected	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	N	Problems breathing or coughing	Y	N
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	N
Any problems with speech	Y	N	Dental braces, caps, or bridges	Y	N	Asthma treatment (past 3 years)	Y	N
Family History						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)				Y	N	Diabetes	Y	N
Any immediate family members have high cholesterol				Y	N	ADHD/ADD	Y	N

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

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any **medications** your child will need to take **in** school:

*All medications taken in school require a separate **Medication Authorization Form** signed by a health care provider and parent/guardian.*

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

Signature of Parent/Guardian _____ Date

To be maintained in the student's Cumulative School Health Record

POTASSIUM IODIDE (KI) FACT SHEET AND PERMISSION FORM

The State of Connecticut is making Potassium Iodide tablets (KI) available to child care facilities and youth camps within the 10-mile emergency –planning zone around Millstone Power Station in Waterford, CT. KI is a form of iodine. It helps to protect the thyroid gland when there is a chance that you might be exposed to a harmful amount of radioactive iodine. In the rare event of a nuclear emergency, your child care provider will be directed when to administer KI through the Emergency Alert System (EAS). Children in child care and youth camps are of the age most likely to suffer the effects of radioactive iodine. Your childcare program or youth camp must obtain your written consent in order to administer KI pills to your child/children. Please remember that the administration of KI to your child under these emergency conditions is voluntary.

Contraindications:

*Your child should not take Potassium Iodide if he/she is allergic to iodine.
*Your child should not take Potassium Iodide if he/she has chronic hives.
*Although a single tablet of KI should be tolerated by most people, some (particularly adults), with a number of rare diseases and conditions should discuss this issue with their physicians. These conditions include:
    *Hypocomplementemic vasculitis, possibly as a component of lupus or chronic hives,
    *Autoimmune thyroid disease, such as Graves disease.

Potential side Effects:

Please consult with your pediatrician if your child experiences any of these side effects:

*Minor upset stomach
*Rash

POTASSIUM IODIDE (KI) CHILD MEDICATION AUTHORIZATION FORM

Name of Child:_____ Date of Birth:_____

Street_____

City:_____ State:_____ Zip:_____

Please indicate your **authorization** or **refusal** by marking the appropriate line below:

_____**YES,** I want my above named child to be administered KI by my provider when: The Governor declares a nuclear emergency, **AND** individuals in specified area, that includes this child care facility/youth camp, are advised by the Emergency Alert System (AES) to take the Potassium Iodide (KI) tablets **AND** I understand that the ingestion of Potassium Iodide (KI) under these circumstances is **voluntary**.

_____**NO,** I do **NOT** want my above named child to be given Potassium Iodide (KI) by my provider in the event of a nuclear emergency. I have been advised in writing by the facility about the contraindications and the potential side effects of taking Potassium Iodide. I understand that it is my responsibility to notify my provider in writing if I desire to change my authorization as indicated above.

_____ _____

(Parent/Guardian Signature) (Date)

Permission Release Form

Acknowledgement of:

First Aid / CPR • Behavior Management • Field Trips • Photos and Videos

Name of Child: _____ Date: _____

First Aid and CPR Permission

I acknowledge that I have read the Accident and Emergency policy in the parent handbook and I give the Drop staff permission to administer First Aid and/or CPR to my child.

_____

Signature of Parent/Guardian

Discipline Policy and Behavioral Guidance

I acknowledge that I have read the Discipline Policy and Behavioral Guidance in the parent handbook and I give the Drop staff permission to use appropriate measures as stated in the handbook.

_____

Signature of Parent/Guardian

Field Trips

I acknowledge that I have read the Field Trip Policy in the parent handbook and I will follow the stated procedures.

_____

Signature of Parent/Guardian

Photo Release

I give consent to the use of photographs/videos taken during our programs for publicity, promotional and/or educational purposes (including publications, presentation or broadcast via newspaper, internet or other media sources). I do this with full knowledge and consent and waive all claims for compensation for use.

____ Yes, I give consent for The Drop-In Learning Center/Camp to photograph my child for program purposes and/or events.

_____No, I do not authorize to The Drop-In Learning Center/Camp to photograph for my child for any event.

_____

Signature of Parent/Guardian

Child and Adult Care Food Program (CACFP)

Income Eligibility Application for CACFP Child Care Centers and Head Start

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 ☐ AM Snack ☐ Lunch ☐ PM 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:** List each person's **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
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:_____

Income Eligibility Application for CACFP Child Care Centers and Head Start

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, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or
2. fax: (833) 256-1665 or (202) 690-7442; or
3. email: program.intake@usda.gov

This institution is an equal opportunity provider.

For more information on the CACFP, visit the Connecticut State Department of Education's (CSDE) CACFP website or contact the CACFP staff at the CSDE, Bureau of Child Nutrition Programs, 450 Columbus Boulevard, Suite 504, Hartford, CT 06103-1841.This document 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/SSI/Medicaid household

☐ Eligible Free ☐ Eligible Reduced ☐ Over Income

Signature of sponsor eligibility official:_____ Date: _____

Child and Adult Care Food Program (CACFP)

Drop-In Learning Center- A CACFP Child Day Care Centers

July 1, 2024, through June 30, 2025

Dear Parent or Guardian:

The Center: A Drop-In Learning and Resource Center, Inc.(Drop-In Learning Center is planning to seek assistance for nutritious meals served under the Child and Adult Care Food Program (CACFP). The CACFP is funded by the U.S. Department of Agriculture (USDA) and administered by the Connecticut State Department of Education.

Our program may receive reimbursement for meals served to children meeting the eligibility criteria for free or reduced-price meals. We must document the eligibility of these children by obtaining family size and income data. Households with incomes at or below the level in "Gross Income Guidelines for Reduced-price Meals" (see page 2) are eligible for free meals. Please complete, sign, date, and return the attached application. **The information you provide will be treated confidentially and will be used only for eligibility determination.**

Please provide the information requested on the enclosed Income Eligibility Application and return as soon as possible. We will use this information to decide the level of CACFP benefit your provider will receive. We may also inform officials of other child nutrition, health, and education programs of the information on your form to determine benefits for those programs.

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 are eligible for free CACFP meals.

- **SNAP or TFA:** If you currently receive SNAP or TFA benefits for your child, you only need to list your child's name, SNAP or TFA case number, and **sign and date** the application.

- **Foster children:** If your household includes a foster child, you only need to list your child's name, check the foster child box, and **sign and date** the application. In accordance with the Healthy, Hunger-Free Kids Act of 2010, foster children who are the responsibility of the state or are formally placed by a state child welfare agency or court are categorically eligible for free CACFP benefits. *This provision does not apply to informal arrangements or placements that may exist outside of state or court-based systems.* Eligibility for formally placed foster children is no longer determined based on their personal use income and a family size of one. The child care institution must obtain documentation from an appropriate state or local agency documenting the child's foster status. Households with both foster and non-foster children may choose to include all

Gross Income Guidelines for Reduced-Price Meals
Effective from July 1, 2024, through June 30, 2025

Number in family	Annual (yearly)	Monthly	Twice per month	Every two weeks (biweekly)	Weekly
1	27,861	2,322	1,161	1,072	536
2	37,814	3,152	1,576	1,455	728
3	47,767	3,981	1,991	1,838	919
4	57,720	4,810	2,405	2,220	1,110
5	67,673	5,640	2,820	2,603	1,302
6	77,626	6,469	3,235	2,986	1,493
7	87,579	7,299	3,650	3,369	1,685
8	97,532	8,128	4,064	3,752	1,876
Each additional family member	9,953	830	415	383	192

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

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