THE DROP-IN LEARNING CENTER

Enrollment Forms Checklist

Today's Date

☐ PRESCHOOL (August-June)

☐ BEFORE SCHOOL (August-June)

☐ AFTER SCHOOL (August-June)

☐ SUMMER ENRICHMENT (June-August)

Child's Name

Parent/Guardian Name

REQUIRED FORMS AND DOCUMENTS

	COMMENTS
1. DILC enrollment application	
2. Registration fee: $50.00 per program (before/after school, summer, and preschool)	
3. Care4Kids application and Parent/Provider form (if applicable)	
4. Child and Adult Care Food Program (CACFP) - mandatory	
5. Current pay stubs (one month) or tax return, and proof of residence	
6. Student Health Assessment: parent/caregiver form and birth certificate	
7. Doctor's office: immunizations, physical examination, medication, and action plan (if applicable)	
8. Potassium Iodide Authorization Form	
9. Permission/Authorization Form	
10. Individualized Education Program (IEP) / 504 Plan	

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Enrollment Application | Application fee: $50 (nonrefundable)

(1) PROGRAM SELECTION

- [ ] Before School (7:00 AM-9:00 AM)
- [ ] Summer Enrichment (8:00 AM-4:00 PM) - school age
- [ ] After School (2:30 PM-5:30 PM)
- [ ] Early Childhood, ages 2.9-5 (8:30 AM-3:30 PM)

(2) CHILD INFORMATION

Name | Date of Birth | Age | M | F

Address | Apt. #

City/State | Zip Code | Phone

Child's School | Current Grade

Select one race category and answer Yes or No under Hispanic/Latino. If Yes, enter the child's ethnicity/country of origin.

RACE CATEGORY	HISPANIC/LATINO	ETHNICITY/COUNTRY OF ORIGIN
White	Yes / No	
Black/African American	Yes / No	
Asian	Yes / No	
American Indian/Alaska Native	Yes / No	
Native Hawaiian/Other Pacific Islander	Yes / No	
Asian and White	Yes / No	
Black/African American and White	Yes / No	
American Indian/Alaska Native and White	Yes / No	
American Indian/Alaska Native and Black/African American	Yes / No	
Other multiracial	Yes / No	

(3) CHILD MEDICAL HISTORY

Does your child have any of the following medical conditions or concerns? Check all that apply. This information is used to ensure your child's well-being and will not affect acceptance.

- [ ] Asthma
- [ ] Wears glasses
- [ ] Needs a hearing aid
- [ ] Frequent nosebleeds
- [ ] EpiPen use
- [ ] ADD or ADHD (hyperactivity)
- [ ] Learning disabilities
- [ ] Special education at school

Does the child have an IEP? Yes / No | 504 Plan

Medication | Allergic Reactions To | Other Serious Medical Condition

Doctor's Name | Doctor's Phone

Doctor's Address / City / State / Zip | Dentist's Name | Dentist's Phone

Dentist's Address / City / State / Zip

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Parent/Guardian, Emergency Contacts, and Financial Information

(4) PARENT/GUARDIAN INFORMATION

Is this child a ward of the state? ○ Yes ○ No

Social Worker

Phone

PARENT/GUARDIAN 1

Name

Relationship

Address (if different)

City/State

Employer

Work Phone

Ext.

Home Phone

Cell Phone

Email

PARENT/GUARDIAN 2

Name

Relationship

Address (if different)

City/State

Employer

Work Phone

Ext.

Home Phone

Cell Phone

Email

(5) EMERGENCY CONTACTS

Two contacts other than the legal guardians are required.

1. Emergency Contact and Authorized Pickup Person

Relationship to Child

Address

Home Phone

Work Phone

Cell Phone

2. Emergency Contact and Authorized Pickup Person

Relationship to Child

Address

Home Phone

Work Phone

Cell Phone

(6) FINANCIAL STATEMENT

Financial assistance received (check all that apply):

- ☐ TANF
- ☐ SNAP
- ☐ General Assistance
- ☐ Social Security Disability
- ☐ Social Security Income
- ☐ Veterans Compensation
- ☐ Care 4 Kids
- ☐ Child Support

THE DROP-IN LEARNING CENTER

Financial Statement (continued), Permissions, and Authorization

Enter your income and family size below. Submit one month of current pay stubs with your application.

Family Size	Weekly Income	Biweekly Income	Annual Income

Child's First Name	Last Name

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

I give permission for my child to participate in transportation by the child care provider when necessary while in care; walking, van, or bus field trips; and computer classes. I will review the policies and procedures in the Parent Handbook and discuss acceptable computer and Internet use with my child.

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

I authorize The Center: A Drop-In Community Learning & Resource Center to use photographs and other recordings of my child's image, voice, and sounds during participation, and to reuse or authorize the reuse of those photographs and recordings, including my child's name, image, and biography, in all media and formats, without compensation or limitation.

Behavior Management

We promote positive behavior management based on praise, humor, modeling, redirection, and choices. If a child does not respond to these strategies, staff will give a verbal warning. If the behavior continues, staff will give a second warning and explain the consequences. After the second warning, staff may:

- Begin an age-appropriate time-out (minutes will not exceed the child's age).
- Limit participation in activities.
- Revoke privileges.
- Contact the parent/guardian.

The following behaviors will not be tolerated: fighting, theft, vandalism, bullying, extortion, and defiance. Consequences may include suspension from the program, restitution for damages, removal from the program, and documentation of any intervention in the participant's file. After a disciplinary intervention, the child will be asked to identify the behavior that led to the intervention and appropriate behaviors for next time.

Methods of Discipline

- Children will be encouraged to think of solutions or alternatives to their own inappropriate behavior, helping them accept responsibility for their actions.
- Children will be redirected from inappropriate behavior toward a more constructive and successful experience through appropriate choices.
- Children will be removed from a provoking situation so they can regain control. If a child loses control or poses a danger to themselves or others, they will be sent to the Head Teacher or Executive Director. The goal is to preserve self-esteem, not exploit or humiliate the child. The child decides how much time is needed before returning to the group.

I authorize The Center: A Drop-In Community Learning & Resource Center to obtain all necessary medical care for my child in an emergency. I understand that I will be contacted as soon as possible if an emergency occurs.

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 Child Care Centers and Head Start

Instructions: Refer to Instructions for the CACFP Income Eligibility Application for 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

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.

CACFP Income Eligibility Application for Child Care Centers and Head Start

Printed name of adult _____ Sign _____ Date _____

Last four digits of Social Security Number (SSN): XXX-XX-____ ☐ I do not have a SSN

Home telephone (with area code):_____ Work telephone (with area code):_____

Home address:_____ y:_____ e:_____ de:_____

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 Bureau of Child Nutrition Programs, 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/SSI/Medicaid household

☐ Eligible Free ☐ Eligible Reduced ☐ Over Income

Signature of sponsor eligibility official:_____ _____

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, 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 ❑ American Indian/ Alaskan Native ❑ Hispanic/Latino	❑ Black, not of Hispanic origin ❑ White, not of Hispanic origin ❑ Asian/Pacific Islander ❑ Other
Primary Care Provider		
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) Authorization Form

All child care programs within a ten-mile radius of the Millstone Power Station in Waterford, CT must notify parents and guardians of enrolled minors, program staff and other persons present of the statutory requirement to distribute and administer potassium iodide to adults present or to a child in attendance during a public health emergency declared by the Governor. Programs must designate program staff members, eighteen years of age or older, to distribute and administer potassium iodide and shall instruct them in the administration of potassium iodide.

Please complete a separate form for each child enrolled.
It is suggested that you consult with your child's primary care physician before completing this form.

Name of Child/Staff: _____

Date of Birth: _____

Address: _____

Name of Parent or Guardian: _____

Home Telephone: _____ Work Telephone: _____

Child's Primary Care Physician: _____ Telephone: _____

Please indicate your authorization or refusal by checking the appropriate box(es) below:

☐ YES, I want my above-named child to be administered KI by my child care provider when:

☐ YES, I want to receive KI when:

- The Governor declares a public health emergency, AND
- Individuals in a specified area, that includes this child care facility, are advised by the Emergency Alert System (EAS) or other communication system 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 KI by my child care provider in the event of a public health emergency.

☐ NO, I do NOT want to be given KI in the event of a public health emergency.

I have been advised in writing by the facility about the contraindications and potential side effects of taking potassium iodide according to current guidelines on exposure, dosage, contraindications and side effects issued by the Food and Drug Administration. I understand that it is my responsibility to notify my provider in writing if I desire to change my authorization as indicated above.

Signature of Parent/Guardian or Staff: _____ Date: _____

Printed Name: _____

For child care program records. Keep this authorization with the child/staff record and update it if the parent/guardian or staff member changes authorization.