ENROLLMENT FORM LIST

Today Date:___

PRE SCHOOL (August -June)	BEFORE SCHOOL (August -June)	AFTER SCHOOL (August- June)	SUMMER ENRICHMENT (June-August)

Child Name: _____

Parent Name: _____

FORMS	COMMENTS
1. DILC ENROLLMENT APPLICATION	
2. REGISTRATION FEE $50.00 (per program i.e. Before/After care, Summer Enrichment & Preschool)	
3. Care4Kids Application and Parent Provider (if applicable) https://portal.ct.gov/oec/care4kids?language=en_US	
4. Child and Adult Care Food Program (CACFP) mandatory	
5. Current Pay Stubs (current for one month) or Tax Return, and Proof of Resident (electric, phone bill or etc.)	
6. Student Health Assessment • Parent/Caregiver Form • Birth Certificate	
7. Doctor Office • Immunization Record • Physical Form • Medication Medication Form with Action Plan (If applicable)	
8. Potassium Iodide Authorization Form	
9. Permission/Release Form	
10. Individualize Education Program (IEP)/ 504 Plan	

Revised 8/11/2026

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

Enrollment Application

Application fees: $50 (non-refundable)

(1) Program Selection

☐ Before Care Program (7:00AM-9:00AM)

☐ Summer Enrichment (8:00AM-4:00PM) school-age

☐ After School Program school-age (2:30-5:30PM)

☐ Early Childhood Education Program 2.9-5yrs (8:30AM-3:30PM)

(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 conditions 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 ☐ SNAP ☐ General Assistance ☐ Social Security Disability ☐ Social Security Income
☐ Veterans Compensation ☐ Care 4 Kids ☐ Alimony

Please write your income and family size below and submit one month of current payroll checks stubs with your application.

Family Size	Weekly Income	Bi-Weekly Income	Annual Income

(7) General Release

Child First Name: _____Child Last 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 themselves. If the child becomes out of control and/or poses a danger to him/herself 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 an emergency arise.

Guardian's Signature_____ Date: _____

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/Parent Provider**			
☐ **Current Paychecks/Tax Return**			
☐ **Student Health Records/Shot Records**			
☐ **Birth Certificate**			
☐ **Potassium Iodide Authorization Form**			
☐ **Release Forms**			

Annual Review of Application

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

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

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) Enrollment Form for Child Care Centers

Our child care center participates in the U.S. Department of Agriculture (USDA) CACFP. This program helps us provide nutritious meals and snacks to children enrolled in our center. For information on the CACFP meal pattern requirements, review the CACFP Meal Patterns for Children and the CACFP Infant Meal Patterns.

Section 1 – Waiver of CACFP Participation

Check here **only** if you are choosing **not** to enroll your child in the CACFP. Complete section 3 on page 2, and return to the child care center.

☐ I do not want my child to participate in the CACFP.

Section 2 – CACFP Enrollment

To verify your child's enrollment in this child care center, complete this section and section 3 on page 2, and return to the child care center. You may be contacted by the center, the Connecticut State Department of Education, or the USDA to verify this information. *Please print all information.*

Child care center's name:_____

Child's name (first and last):_____ Birth date (month/day/year):_____

☐ Male ☐ Female First day of attendance:_____

Days and hours of care and meals served

Complete the chart below. My child will normally be in child care during the following days and times and will receive the meals indicated below.

Normal days of care *Check all that apply*	☐ **Monday**	☐ **Tuesday**	☐ **Wednesday**	☐ **Thursday**	☐ **Friday**	☐ **Saturday**	☐ **Sunday**
Normal hours in care *Circle AM or PM*	_____ AM/PM to _____ AM/PM and _____ AM/PM to _____ AM/PM	_____ AM/PM to _____ AM/PM and _____ AM/PM to _____ AM/PM	_____ AM/PM to _____ AM/PM and _____ AM/PM to _____ AM/PM	_____ AM/PM to _____ AM/PM and _____ AM/PM to _____ AM/PM	_____ AM/PM to _____ AM/PM and _____ AM/PM to _____ AM/PM	_____ AM/PM to _____ AM/PM and _____ AM/PM to _____ AM/PM	_____ AM/PM to _____ AM/PM and _____ AM/PM to _____ AM/PM
Meals normally served to my child *Check all that apply*	☐ Breakfast ☐ AM snack ☐ Lunch ☐ PM snack ☐ Supper ☐ Evening snack	☐ Breakfast ☐ AM snack ☐ Lunch ☐ PM snack ☐ Supper ☐ Evening snack	☐ Breakfast ☐ AM snack ☐ Lunch ☐ PM snack ☐ Supper ☐ Evening snack	☐ Breakfast ☐ AM snack ☐ Lunch ☐ PM snack ☐ Supper ☐ Evening snack	☐ Breakfast ☐ AM snack ☐ Lunch ☐ PM snack ☐ Supper ☐ Evening snack	☐ Breakfast ☐ AM snack ☐ Lunch ☐ PM snack ☐ Supper ☐ Evening snack	☐ Breakfast ☐ AM snack ☐ Lunch ☐ PM snack ☐ Supper ☐ Evening snack

For infants only

Name of approved iron-fortified infant formula* offered by center:_____

Check all that apply:

- ☐ I would like my child to receive the iron-fortified infant formula supplied by the center, as listed above.
- ☐ I will provide my own infant formula (list name of approved iron-fortified infant formula* below):

  _____
- ☐ I will provide expressed breast milk for my child.
- ☐ I will breastfeed my child on site in the center.

* **Note:** Infant formula provided by the parent/guardian must be **iron-fortified** and comply with the USDA's infant formula regulations indicated in USDA Memo CACFP 06-2025: Feeding Infants and Meal Pattern Requirements in the Child and Adult Care Food Program; Questions and Answers. Infant formulas that do not meet these requirements cannot be substituted unless an infant has a disability that restricts their diet, and the parent/guardian provides a medical statement signed by a state licensed healthcare professional or registered dietitian. Medical statements are available on the Connecticut State Department of Education's (CSDE) Special Diets in CACFP Child Care Programs webpage.

Section 3 – Contact Information and Signatures

Parent/guardian name:_____

Address (city, state, zip code):_____

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

Parent signature:_____ Date:_____

Sponsor representative's signature:_____ Date:_____

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 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;
(2) fax: (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 CSDE's CACFP website or contact the CACFP staff at the Connecticut State Department of Education, 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/enroll/cacfp_enrollment_form_centers.pdf.

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.