



Early Childhood Center
2155 University Ave.
Bronx, New York 10453
Tel: (718) 289-5461
Fax: (718) 289-6432
Email: bcckids@bcc.cuny.edu

**CAREFULLY READ AND REVIEW THE ENTIRE PACKET.
ENCLOSED ARE THE FORMS YOU NEED TO FILL OUT AND RETURN.**

On the day of your scheduled appointment, you will need to bring the following documents to meet with **Administration** to the center:

- ✓ Registration Application
- ✓ Parent Fee Agreement (Contract)
- ✓ Emergency Contact Form
- ✓ Family Social/Developmental History
- ✓ Permission to Pick-Up & Drop-Off
- ✓ Media Release Form
- ✓ Informed Consent Form
- ✓ Authorization and Release For Emergency Medical Treatment
- ✓ Enrollment/Registration CACFP
- ✓ CACFP Food Form (Child and Adult Care Food Program) fill out completely include all income information.
- ✓ Child's Current Medical Record (must be completed by doctor)
- ✓ Immunization Card/ Printout
- ✓ Original Child's Birth Certificate (Copies not accepted)
- ✓ Class Schedule from CUNYFirst with Name and EMPLID ID
- ✓ BCC Identification Card
- ✓ Income Verification and Documentation
(Current Income Tax, PA Card along with a Notarized Letter, 3-6 Pay Stubs, Child Support Letter, Notarized Statement Letter with Income Status)



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Dear Parents:

On behalf of the BCC Early Childhood Center, I want to welcome you and your child. We are looking forward to an exciting school year.

Please allow me to introduce myself. My name is Jitinder Walia, and I am the Executive Director of the BCC Early Childhood Center. I consider having the opportunity to serve the children, and their parents at BCC as an honor. My office hours are generally Monday through Friday from 7:30am to 3:30pm. I am also available for evening hours. I encourage parents stopping in to say hello, and anticipate meeting your children in the coming weeks. My email address is jitinder.walia@bcc.cuny.edu.

Just a little bit about myself and my extensive experience working with families: I have been in the Early Childhood field for the past 33 years. I have three Master's degrees; one with a concentration in Early Childhood Education, one in English, and the other in Social Work. I also have a certification in Administration and Supervision. My experience has been working in private daycare centers, with foster children, parents, adolescent, and substance abusing women. I am most proud of being a graduate of CUNY. Ideas and opportunities to continue to enrich our program here at BCC are welcomed.

A key component of a good early childhood program is parent involvement. All parents are encouraged to communicate with their child's teacher on a daily basis. This will ensure all parents are informed of the day's activities, as well as upcoming events in the classroom. Please make sure you check your child's cubbies each day.

The staff has planned a creative curriculum that includes art, music, science, cooking, outdoor play, dramatic play and literacy. In order for your child to participate in all of the activities offered, please have your child arrive at the agreed upon time. This policy will be strictly enforced.

The program provides nutritious meals for the children. **Breakfast will be available only until 9:30am**, lunch is served at approximately 11:30am.

This semester we have a long wait list for childcare. If your child will be absent from school, it is your responsibility to call the center. Please be informed that **excessive absences, without explanation are cause for termination of services**. Please let us know of any schedule changes, or if you need to withdraw your child.

If you have any questions, please do not hesitate to set up an appointment. Thank you for your cooperation.

Sincerely,

Jitinder Walia

Executive Director



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Dear Parent,

You have been selected to **begin the enrollment process** at the BCC Early Childhood Center. We hope that this will be the beginning of a long and rewarding relationship for us all. Before your child can actually be accepted into our center, there are some things you need to do and to know:

1. First, please **CAREFULLY REVIEW THIS PACKET**. In it are forms that you need to fill out and return on the day of your appointment. *(You must complete all forms and return them to us before your child can be formally accepted into our program.)*
2. Then, **Call to schedule an appointment to register your child. PLEASE CALL ADMINISTRATION WITH ANY QUESTIONS AT 718-289-5461.**
3. **NOTE!** To insure full classrooms at our center, we often select more parents to begin enrollment than we have immediate room for. This means two things. First, the more quickly you respond and complete the enrollment process, the sooner your child will be able to begin. And second, there is a chance that we will need to place you on our Priority Waiting List until a space opens in a classroom that is age appropriate for your child. Once you are on the Priority Waiting List, your child will automatically be accepted as soon as space becomes available.

These forms must be completed and returned to the office on the day of your appointment:

- Registration Application
- Parent Fee Agreement (Contract)
- Emergency Contact Form
- Family/Social/Development History
- Permission for Visits, Pick-Up and Drop-Off
- Media Release Form
- Informed Consent Form – signed
- Authorization and Release for Emergency Medical Treatment
- CACFP Enrollment Form
- CACFP Food Form (USDA)
- Child's Medical Record – needs to be completed by your doctor or clinic (Must have doctor stamp and hospital or clinic stamp)
- Proof of Income (Acceptable proof includes: Current Tax Return, Pay Stubs, PA Card, Notarized Letter of Support w/Income Tax, Unemployment Papers)
- BCC Identification Card
- Child's Birth Certificate
- Your Complete Class Schedule

Most of these forms are required by law. But they also help us bring in the funding that keeps our parent fees low and help us protect and meet the needs of your child. Again, please be sure to have all requested forms completed and signed before returning.

The forms in this packet will help you better understand the policies and the educational philosophy of the BCC Early Childhood Center.

Sincerely,
The BCC Early Childhood Center



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REGISTRATION APPLICATION

BCC EARLY CHILDHOOD CENTER

This application is the first step toward enrolling your child in the Early Childhood Center at Bronx Community College. **If you are called, you will need to contact us immediately (by telephone or in person) to schedule a visit to the Center for you and your child.** Please note that there will also be additional forms to fill out. The full process must be completed before your child can be accepted in our program.

Information on this side refers to the **PARENT** (BCC Student). **Please Print Clearly.**

Parent's Name _____ SS#: XXX/ XX/ _____
(Last) (First) (Middle Initial)

Parent's Address _____
(Street Number) (Apt. #)

(City) (State) (Zip Code) () (Telephone)

Major _____ Email: _____
EMPLID ID _____

**Please attach a complete front and back copy of your CLASS SCHEDULE.
If your child is accepted, you will need to provide a current schedule for each semester.**

Have you been awarded Federal Work Study? YES NO

If yes, please list the name of the department and hours you anticipate working.

EMERGENCY CONTACT (if parents cannot be reached)

(Print Name) () (Telephone #) (Relationship to the child)

I have read and completed this application fully and carefully.

(Signature) (Date)

REMEMBER TO FILL OUT BOTH SIDES OF THIS APPLICATION

Information on this side refers to CHILD for whom the services will be provided. Please print:

Child's Name _____ / ____ / ____
(Last) (First) (M.I.) (Date of Birth)
Child's Age _____ Male _____ Female _____
Child's Address _____
(Street Number) (Apt. #)
() _____
(City) (State) (Zip Code) (Telephone)

Parental Info.	Parent/Guardian	Parent/Guardian
Name		
Date of Birth		
Occupation		
Work Address		
Daytime Phone #		
Email Address		

Marital Status: (check one)
____ Single ____ Married ____ Separated ____ Divorced

Other Members of the household

Full Name	Birth Date	Age	Relationship to Child

Are there any other important adults in your child's life?

Previous Experience Outside Home	Where?	How Frequently?
Public/Private School		
Family Day Care		
Extra Curricular		
Other		

Reaction to experience away from home: _____

REMEMBER TO FILL OUT BOTH SIDES OF THIS APPLICATION



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TUITION POLICY

Tuition

Bronx Community College Early Childhood Center offers childcare at a heavily subsidized rate of \$5 per day. Along with our rates, there is also a New Student registration fee of \$25. Every semester after, there will be a re-enrollment fee of \$15. Tuition is calculated based on the total number of weeks in your enrolled semester. How do I calculate the number of weeks per semester? That's easy, the answer is:

- Fall or Spring Semester: 16 weeks x days per week x \$5 = Total tuition for each semester
- Winter Semester: 3 weeks x days per week x \$5 = Total tuition
- Summer Semester: 3-8 weeks (depending on the calendar year)
Number of weeks x days per week x \$5 = Total tuition

NOTE: Some courses may extend longer than others, in this event; your tuition will reflect the total number of weeks for that course.

Tuition is charged on a weekly basis for the days you are scheduled in the entire semester. **Non-attendance or college closure will not be a reason to adjust your tuition.** Tuition **MUST** be paid prior to your child's identified start date. It may be paid in full or in installments on the 23rd of each month during your enrolled semester. All payments should be made at the Bursars office. **Unpaid tuition will result in a hold in your CUNY First account and an interruption of services and will remain interrupted until the balance is satisfied.**

**HRA vouchers are gladly accepted*

Request for Tuition Reimbursement

Partial tuition reimbursement is provided to eligible student-parents and must be approved by the Executive Director. **Eligibility requirements state that you notify the childcare center of any changes to your class schedule including withdrawals no later than two weeks into your enrolled semester.** You may request a schedule change form from the childcare center.

Record keeping

You are responsible for maintaining an accurate record of your validated receipts. Do not discard of your receipts as it will assist in verifying payments made toward your account.



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PARENT FEE AGREEMENT

****PLEASE INCLUDE YOUR PROOF OF INCOME****

(Current Income Tax, Paycheck Stubs, PA Card, Notarized Statement Letter)

PARENT'S SOCIAL SECURITY #: XXX / XX / _____

Circle one: FULL TIME / PART TIME NUMBER IN HOUSEHOLD: 2 3 4 5 6
FALL / SUMMER I / SUMMER II / SPRING _____

I/We, _____ parent(s)/legal guardian(s) of
(Parent / Guardian's name)

_____ enter this agreement with the BCC
(Child's name)

Early Childhood Center located at 2155 University Avenue, Bronx, NY 10453 for the provision of child care. I/We agree to the following terms:

1. I agree to pay the Center a New Student registration fee of **\$25.00**.
(This fee is not refundable.)
2. I agree to pay the Center a re-enrollment fee of **\$15.00** every time I re-enroll my child/ren.
3. I agree to pay the Center a subsidized fee for the entire semester I register for childcare services.
(This fee should be paid to the bursars' office)
4. I affirm that I am a BCC student majoring in _____ and I am presently taking # _____ course hours.
5. These amounts listed are based on family size of _____ and gross annual income of \$ _____.
6. **THE CENTER RESERVES THE RIGHT TO TERMINATE THE CONTRACT AT WILL.**

Parent's Signature

Date

NO REFUND FOR NON-ATTENDANCE

For Office Use:

Semester:

Registration Fee \$ _____.

Tuition per semester \$ _____.

Total tuition \$ _____.



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EMERGENCY IDENTIFICATION FORM

CHILD'S INFORMATION

Child's name: _____ D.O.B: _____
Allergies: _____
Medications: _____

PARENT AND OR/LEGAL GUARDIAN INFORMATION

Social Security #: xxx - xx - _____
Full Address: _____
Home Phone #: (____) _____
Cell Phone #: (____) _____
Alternate #: (____) _____

EMERGENCY CONTACT 1

Name: _____ Date of Birth: _____
Home Phone #: _____
Cell Phone #: _____
Address: _____
Relationship to child: _____

EMERGENCY CONTACT 2

Name: _____ Date of Birth: _____
Home Phone #: _____
Cell Phone #: _____
Address: _____
Relationship to child: _____

PLEASE READ CAREFULLY; SIGN YOUR NAME AND DATE WHERE INDICATED

I hereby grant permission for the Director or a member of the professional staff of The Early Childhood Center at Bronx Community College, to take whatever steps may be necessary to obtain emergency medical care if warranted. These steps may include, but are not limited to, the following:

- Contact student-parent on campus.
- Contact persons listed on emergency form/card submitted to the Center.
- Obtain emergency medical care or referral from the Bronx Community College Health Services Center.
- Transportation by emergency medical vehicle to nearest hospital.
- NOTE:** People on the Emergency Contact List **may not** Pick-up or Drop off your child/ren.

The Center will not be responsible for anything that may happen as a result of false information given at the time of enrollment.

The Center will not assume responsibility for a child who has not signed in when he/she arrives for the day.

SIGNE: _____ **DATE:** _____

FAMILY/SOCIAL/DEVELOPMENTAL HISTORY

Child's Name _____ Date of Birth _____

Mother/Guardian _____ D.O.B: _____

(Include Maiden Name)

Address _____

Telephone # _____

Occupation _____ Birthplace _____

Father/Guardian _____ D.O.B: _____

Address _____

Telephone # _____

Occupation _____ Birthplace _____

Is the child your birth child? _____ Foster or adopted? _____ At what age? _____

Does your child know he/she is adopted? _____ (Please provide supporting documents)

Marital Status of Parents: (Check all that apply)

Never married? _____ Married? _____ Living together? _____ How Long? _____

Seperated? _____ How Long? _____ Divorced? _____ How Long? _____

Custody / visiting arrangements? **Yes/No**

Explain: _____

(Please provide supporting documents)

Is mother or father married or living with another partner? **Yes/No**

Explain _____

Brothers and Sisters of Child:

Name _____ D.O.B. _____ Lives in home? _____

Name _____ D.O.B. _____ Lives in home? _____

Other persons living in the household (include relationship and age?) _____

Who cares for child other than parents? _____

Health History:

How would you describe your child's overall health? _____

What past illnesses has your child had and at what ages? _____

What hospitalizations or serious accidents has your child had? _____

Does your child have frequent colds? _____ Ear aches? _____ High fevers? _____ Stomach
aches? _____ Other illnesses? _____

Is your child receiving special services? (If yes, please attach the supporting documentation)

Social / Developmental History:

At what age did your child: Walk? _____ Talk in simple sentences? _____
Become toilet trained? _____ Dress self? _____

Speech:

Does your child express his/her self well? _____ If not, what difficulties is your child having with his/her speech? _____
What language(s) does your child speak? _____

Eating:

How is your child's appetite? Good _____ fair _____ poor _____ irregular _____
Food favorites? _____
Food dislikes? _____
Does child feed self? _____ Fork? _____ Spoon? _____
What if any dietary restrictions do your family have? _____
Food allergies? _____

Sleeping:

What time does your child go to bed? _____ Get up? _____
Where does your child sleep? In own room? _____ In room with? _____
In own bed? _____ In bed with? _____
Does your child sleep through the night? _____ Have bad dreams? _____
If yes, describe? _____

Toileting:

Does your child have toilet control? _____ If accidents, when and what kind? _____

Personality:

How would you describe your child's personality? _____
How does your child act with adults? _____
With children? _____
What are your child's special interests? _____
What are your child's fears? _____

Discipline:

What method of discipline is used in your home? _____
What is your child's usual reaction? _____
In what area does your child have the most difficulty cooperating? _____
What do you do to get your child to cooperate? _____

Play/ Activities:

What is your child's favorite: Indoor play activities? _____
Outdoor play activities? _____
Has your child had group play experience? _____ Where? _____
What does your child watch on TV? _____
How many hours a week? _____
What play activities does your child dislike? _____

SIGNATURE: _____ **DATE:** _____



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PERMISSION FORM

Pick Up and Drop Off

I _____, PARENT OF _____,
(Parent's Name) (Child's Name)

Do hereby give permission for the following people to drop off/pick up my child:

Print Name: _____ Relation to child: _____ Number: _____

D.O.B. _____

Print Name: _____ Relation to child: _____ Number: _____

D.O.B. _____

Print Name: _____ Relation to child: _____ Number: _____

D.O.B. _____

I agree to drop off and pick up my child at the times set in my schedule. If any changes occur, I agree to give at least one (1) days' written notice. I am aware that the Early Childhood Center closes at 5:30PM and must personally pick up or have someone pick up my child by 5:20PM (if applicable).

Parent's Signature: _____ *Date:* _____

Changes made and/or addition/date:

Media Release Form (Child)

I am the parent or legal guardian of _____ (*child's name*). I hereby grant permission to The City University of New York and anyone acting pursuant to its authority (collectively "CUNY") to take photographs, video and/or film recordings, and/or audio recordings of my child while participating in activities of a CUNY child care center. I authorize the use of such recordings, for any purpose that CUNY may deem appropriate, including without limitation educational uses and promotion of CUNY and its programs and activities, including in particular CUNY child care centers, in perpetuity, in CUNY publications and promotional materials, websites and social media sites, as well as in all other media and manners, whether now known or later developed. I waive any right to inspect and approve such uses. I understand that such recordings of my child may identify the CUNY child care center that my child attends, but they will not identify my child by name. I understand that CUNY will be the owner of all rights in and to such photographs, videos and uses and that neither I nor my child will receive any monetary or other compensation for such uses.

I hereby release and hold harmless CUNY from liability for any and all claims by me in connection with CUNY's activities as authorized by this consent and release.

I understand that I am not required to sign this release as a condition of enrollment of my child in a CUNY child care center or participation in a center's programs and activities.

Printed Name of Parent/Legal Guardian

Date

Signature

Phone #

Address

City

State/Zip

**Authorization and Release
For Emergency Medical Treatment**

Child's Name	Child's Date of Birth
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I am the parent or legal guardian of the above named child.

My child is enrolled at **BRONX COMMUNITY COLLEGE EARLY CHILDHOOD CENTER.**

By signing this form, I authorize the Center to obtain emergency medical care for my child if my child is injured or becomes ill while in the Center's physical custody and the Center deems such care to be necessary. I also authorize the Center to arrange for any needed transportation for my child if my child needs emergency medical care.

In addition, by signing this form, I acknowledge that:

(1) I have been advised that New York City's Department of Health is now requiring center based child care programs, including the Center, to give epinephrine to a child with symptoms of anaphylaxis (severe allergic reaction that can be caused by certain foods, insect stings, latex or some medications). I understand that anaphylaxis can be life- threatening and requires emergency treatment. Epinephrine is widely regarded as an appropriate treatment.

(2) I have been advised that if a child shows symptoms of anaphylaxis, the epinephrine will be administered by trained staff using an epinephrine auto-injector (dosed for children) with a retractable needle, consistent with New York City's Department of Health regulations (Articles 43 and 47 of the NYC Health Code).

By signing this form, I authorize the Center to administer epinephrine using an epinephrine auto-injector (dosed for children) with a retractable needle if my child shows symptoms of anaphylaxis (severe allergic reaction).

I understand that if I have provided a written, individual health care plan to the Center indicating the specific medications that can be administered and the schedule of such administration(s) for my child, including in cases of emergency, and there is a direct conflict between such plan and any of my other authorizations in this Authorization and Release, then the Center will follow my child's individual health care plan.

I hereby release and forever discharge **BCC EARLY CHILDHOOD CENTER , BRONX COMMUNITY COLLEGE**, The City University of New York, The Research Foundation of the City University of New York, New York State and New York City, and the directors, officers, employees and agents of each of them from any and all liability arising in law or equity as a result of the Center providing emergency treatment in conformance with this Authorization and Release provided that the Center has used reasonable care in carrying out such actions.

I HAVE READ THIS AUTHORIZATION AND RELEASE AND UNDERSTAND IT, AND I AM SIGNING IT VOLUNTARILY.

Parent or Legal Guardian's Name (please print)	
Signature	Date

INFORMED CONSENT FORM

Access

I will be able to visit my child in the classroom at any time except for nap-time (12pm-2pm).

Arrival and Departure

If enrolled in the preschool program, I will make sure that my child arrives at the Center no earlier than 15 minutes prior to the start of my scheduled class. To ensure my child's safety, the center will only accept my child from or release my child to those persons I have authorized on the Pick Up Release Form. I will pick up my child no later than 15 minutes after my last class scheduled ends for the day. I am also aware that the Early Childhood Center closes at 5:30PM sharp and will pick up my child no later than 15 minutes prior to close (if applicable). I am also aware that there is no drop-off between 11:00am-1:45pm.

Staff

Qualified staff will be present at all times in staff-to-child ratios meeting the New York City Department of Health regulations.

Meals

Children will be served breakfast and lunch. Meals are provided by CACFP, the food service program. Menus will be available on a regular basis. I am allowed to bring food from outside provided that the food is healthy and follows the guidelines set by the Department of Health.

Trips

I give permission for my child to participate in walks around the college or in the area with appropriate staff supervision.

Media Images

I give consent for the Center to use media images (i.e. photographs, videotapes) for documentation of the classroom program, research, public education, promotion and news reports. I will be asked for additional permission before my child is *individually identified* in a published photograph.

Research

BCC students and faculty and those from other colleges may conduct observational research of my child. If my child is to participate in any interactive research, I will be asked to sign a release.

Emergency and Medical Procedures

In case of illness, I will be called and possibly required to pick up my child as soon as possible.

I have read and agree to the terms of this consent form:

Print Child's Name _____ **D.O.B.** _____

In case of simple injury, (abrasion, skinned knees, splinters, etc.), the center staff will perform routine first aid measures, such as washing wounds and applying bandages. I will be informed when I arrive to pick up my child any incidents and the actions taken. In case of a medical emergency, I will be called and will take responsibility for obtaining the necessary medical treatment. If, in the judgment of the Center staff, circumstances require immediate or professional care, 911 services will be called by BCC's Office of Public Safety. In the event emergency treatment is required I give consent for my child to be taken to a nearby medical facility for treatment by a qualified physician. Costs incurred from treatment of an injury or illness occurring within the program is my responsibility.

Children's Records

All children's records are kept confidential. Upon written request, I may receive a copy of my child's records. Except in the case of appropriate state and city officials, who have the right to inspect center files at any time, my child's records will not be released to anyone unless authorized by me in writing.

Group Care and My Child

To the best of my knowledge, my child has no condition that restricts his/her full participation in the Center program. If in the future any restrictions are necessary, I will inform the Center in writing.

The Center adheres to the guidelines of the Americans with Disabilities act. We serve children who are able to function in a group setting and will make every effort to facilitate this. However, occasionally, if we are unable to meet the needs of a particular child, the Center may ask the family to withdraw their child.

Child Abuse and Neglect

The Center operates accordingly to a plan designed to protect children from any danger of abuse or neglect. Center staff members are required by law to report to the State's Child Abuse and Maltreatment Hotline any evidence that a child has been or is in danger of being abused or neglected.

Parent/Guardian Signature

Print Parent/Guardian Name

Date

BCC Early Childhood Administrator

Date

Building for the Future

This day care facility participates in the Child and Adult Care Food Program (CACFP), a Federal program that provides healthy meals and snacks to children receiving day care.

Each day more than 2.6 million children participate in CACFP at day care homes and centers across the country. Providers are reimbursed for serving nutritious meals that meet USDA requirements. The program plays a vital role in improving the quality of day care and making it more affordable for low-income families.

Meals CACFP homes and centers follow meal requirements established by USDA.

Breakfast	Lunch or Supper	Snacks (Two of the four groups:)
Milk Fruit or Vegetable Grains or Bread	Milk Meat or meat alternate Grains or bread Two different servings of fruits or vegetables	Milk Meat or meat alternate Grains or bread Fruit or vegetable

Participating Facilities Many different homes and centers operate CACFP and share the common goal of bringing nutritious meals and snacks to participants. Participating facilities include:

- **Child Care Centers:** Licensed or approved public or private nonprofit child care centers, Head Start programs, and some for-profit centers.
- **Family Day Care Homes:** Licensed or approved private homes.
- **Afterschool Care Programs:** Centers in low-income areas provide free snacks to school-age children and youth.
- **Homeless Shelters:** Emergency shelters provide food services to homeless children.

Eligibility State agencies reimburse facilities that offer non-residential day care to the following children:

- children age 12 and under,
- migrant children age 15 and younger, and
- youths through age 18 in afterschool care programs in needy areas.

Contact Information If you have questions about CACFP, please contact one of the following:

Sponsoring Organization

State Director, NYS CACFP
NYS Department of Health
Division of Nutrition
150 Broadway FL 6 West
Albany, NY 12204-2719
1-800-942-3858 (in NY only)
518-402-7400



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ENROLLMENT/REGISTRATION CACFP

Continuing Student

Child's Name:

Male or Female

Date of Birth

Home Phone

Home Address:

Mother/Guardian Name

Father/Guardian Name

Parent/Guardian Address/Phone number if different than children

In case of emergency notify / Telephone #:

Second person to notify / Telephone #:

Physician name / Telephone #:

-Breakfast is served at 8:30 am

-Lunch is served at 11:30 am

-Afternoon snack will be served between 3:00 and 3:30 PM

What days/times will your child usually be at the center? Arrival _____ am/pm

M__ T__ W__ Th__ F__ '

Departure _____ am/pm

A menu is available on a regular basis. If your child is in care during these times, he or she will receive the meal or snack that is being served.

Dear Parent, Guardian or CACFP Participant,

This center participates in the Child and Adult Care Food Program (CACFP) and provides healthy meals at no cost to all children and adults enrolled in care. By completing and returning the attached income eligibility form, you will help your center receive money from CACFP for the meals that are served. If your household's income is equal to or less than the amounts indicated for your household size on the chart below, the center will receive a higher rate of funding for the meals served. The form needs to be completed every year. The information is used only for CACFP purposes.

**INCOME ELIGIBILITY GUIDELINES
(Effective July 1, 2019 until June 30, 2020)**

HOUSEHOLD SIZE	REDUCED-PRICE MEALS		
	YEAR	MONTH	WEEK
1	23,107	1,926	445
2	31,284	2,607	602
3	39,461	3,289	759
4	47,638	3,970	917
5	55,815	4,652	1,074
6	63,992	5,333	1,231
7	72,169	6,015	1,388
8	80,346	6,696	1,546
FOR EACH ADDITIONAL FAMILY MEMBER	+8,177	+682	+158

SPONSOR/CENTER OFFICIAL

SPONSORING ORGANIZATION

DATE

This institution is an equal opportunity provider.

See INSTRUCTIONS on reverse.

CHILD CARE CENTER NAME: Bronx Community College Early Childhood Center

Print the name of the child(ren) enrolled in this child care center:

1. _____ 2. _____ 3. _____

DIRECTIONS:

Complete SECTION A if anyone in your household:

1. Receives Food Stamps
2. Receives Temporary Assistance to Needy Families (TANF)
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR) OR
4. If any of the children enrolled in this child care center are foster children

SECTION A	
Food Stamp Case Number	_____
TANF Number	_____
FDPIR Number	_____
Names of Foster Children	_____
<p>An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.</p> <p>I certify that the above information is true. I understand that the center will get Federal funds based on the information I give.</p> <p>Signature: _____</p> <p>Date: _____</p>	
FOR SPONSOR USE ONLY	
<p>Sponsor Agreement Number _____</p> <p>Total Household Members _____ (including foster children, if applicable)</p> <p>Total Income \$ _____</p> <p>Free _____ Reduced _____ Paid _____</p> <p>Date Determined ____ / ____ / ____</p> <p>Signature of Center Staff _____</p>	

Complete SECTION B if no one in your household receives Food Stamps, TANF, FDPIR or if none of the children enrolled in the child care center is a foster child.

SECTION B	
<p>List all household members below. Include yourself and all adults and children NOT listed above, even if they do not receive income. Then list all income received last month in your household in the column to the right. Gross income includes: earnings from work, pensions, retirement, Social Security, child support, foster child's personal income and any other sources of income.</p>	
Name of Household Members	Monthly Gross Income
1. _____	\$ _____
2. _____	\$ _____
3. _____	\$ _____
4. _____	\$ _____
5. _____	\$ _____
6. _____	\$ _____
<p>An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.</p> <p>I certify that the above information is true and that all income is reported. I understand that the center will get Federal funds based on the information I give.</p> <p>Signature: _____</p> <p>Print Name: _____</p> <p>SS# <u>XXX-XX-</u>____ Date: _____</p>	

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this form. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the form. The Social Security Number is not required when you apply on behalf of a foster child or you list a Food Stamps, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the form does not have a Social Security Number. We will use your information to determine if the center is eligible for free or reduced-price meal reimbursement and for administration and enforcement of the Program.

INSTRUCTIONS FOR COMPLETING DOH-3688

Definition of Income

Income means income before deductions for income taxes, social security taxes, insurance premiums, charitable contributions, and bonds, etc. It includes the following: (1) monetary compensation for services, including wages, salary, commissions or fees; (2) net income from non-farm self-employment; (3) net income from farm self-employment; (4) Social Security payments; (5) dividends or interest on savings or bonds, income from estates or trusts or net rental income; (6) unemployment compensation; (7) government civilian employee or military retirement, or pensions or veteran's payments; (8) private pensions or annuities; (9) alimony or child support payments; (10) regular contributions from persons not living in the household; (11) net royalties; (12) military benefits received in cash, such as housing allowance except if you are in the Military Housing Privatization Initiative; and (13) any other cash income.

Definition of Household

Household means *family* as defined in Section 226.2. *Family* means a group of related or non-related individuals who are not residents of an institution or boarding house, but who are living as one economic unit.

Instructions for Parents or Guardians:

Write in the name of the child care center in the space provided.

Print the name of each child in your household who attends this child care center.

Section A: If anyone in your household receives Food Stamps, Temporary Assistance for Needy Families (TANF) or participates in the Food Distribution Program on Indian Reservations (FDPIR), complete Section A only. Write down the Food Stamp, TANF or FDPIR number (do not use your ACS or DSS child care subsidy number). Then sign and date the form and return it to the day care center.

Foster children: If your household includes a foster child who is in child care, write in the names of the foster children.

Section B: Complete this section if you did not complete Section A. Write in your name and the names of all other adults and children living in the household, including unrelated people, even if they do not have any income. Do not include the children in child care who are listed at the top of the form.

Enter the amount of income each person received **last month**, before taxes or anything else was taken out. Refer to the Definition of Income and the Definition of Household, above. If any amount last month was more or less than the usual, write in that person's usual income.

The last four digits of the Social Security Number of the adult signing the certification is required. If you do not have a Social Security Number, write *none*. The form must be signed by an adult member of the household.

Instructions for Centers and Sponsors:

The For Sponsor Use Only section is to be completed, signed and dated by center or sponsor staff. The sponsor/center representative must review the income eligibility form and ensure that it is completed as indicated in the instructions above. Then indicate the following:

The Sponsor Agreement Number.

Total Household Members – This item does not have to be completed if the parent completed Section A. Add those indicated in Section B (if completed) to the children enrolled in child care and the number of foster children, if applicable.

Total Income – This item does not need to be completed if the parent completed Section A. Indicate the total monthly income as calculated from Section B. If the parent chooses not to disclose income, the form must be categorized as *paid*.

Free, Reduced or Paid – Compare the total household income and the total number of household members with the current year's Income Eligibility Guidelines (CACFP-3687) to determine if the household should be categorized as **Free, Reduced** or **Paid**. Use the appropriate column on the CACFP-3687 to categorize their income. For example, if the parent indicated biweekly income, multiply this amount by 26 to determine yearly income.

Incomplete forms (missing signatures, income information, or Food Stamp, TANF or FDPIR numbers) are categorized in the paid category.

The income eligibility form is valid until the last day of the month one calendar year from the date it is signed by the household member. For example, a form signed on May 12, 2011 is valid until May 31, 2012.



Bronx Community College Early Childhood Center

PLEASE BRING NUTRITIOUS FOOD FOR YOUR CHILD

What Parents Should Know About the Benefits of the Child and Adult Care Food Program

The child care facility you have chosen is a participant in the **Child and Adult Care Food Program (CACFP)**. The main goal of this program is to insure that children in participating child care centers and family child care homes receive healthful meals and snacks and child care providers receive training in nutrition. Children and providers learn about food and healthy eating. Only 100% juice shall be permitted and children shall receive no more than six (6) ounces per day. This is why we are asking you not to bring in fast food for your child to eat.

Nutrition is an important part of good child care and a healthy lifestyle. All children need well-planned meals and snacks that provide a variety of foods and the nutrients needed for good health and energy. The United States Department of Agriculture (USDA), through the New York State Department of Health, helps child care providers pay for meals and snacks that meet nutrition requirements for breakfast, lunch or supper, and snacks. A meal pattern outlines the kinds and amounts of food that must be served. Training and educational programs are also offered to child care providers that participate on the CACFP.

Child care facilities on this program:

- Care about good nutrition for children
- Plan nutritious meals and snacks
- Help children learn and feel positive about food and eating

You should also know that:

1. We as your provider may ask you to complete certain forms required by CACFP.
2. *We do not provide any substitutes. If your child is allergic to certain foods please inform the center at registration so a note can be made for classroom teachers. Please make sure everything is labeled properly with child's name when sending food from home.*
3. To help manage the program better, you may be contacted at some time and asked about the type and quality of meals that your child receives while in care.
4. We cater our food from a private vendor and will be glad to provide menus for meals and snacks to you.

Working together, we can help your child establish healthful food habits that will last a lifetime. You may receive other information from us that will suggest ways you can help your child learn about food and healthy eating. As a parent, you are the most important teacher your child will ever have. **By practicing good health habits, including healthy eating, you can give your child a head start on a healthy lifestyle.**

CHILD & ADOLESCENT HEALTH EXAMINATION FORM NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION					Please Print Clearly		NYC ID (OSIS)																								
TO BE COMPLETED BY THE PARENT OR GUARDIAN																															
Child's Last Name					First Name				Middle Name				Sex <input type="checkbox"/> Female <input type="checkbox"/> Male		Date of Birth (Month/Day/Year) ____/____/____																
Child's Address							Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No		Race (Check ALL that apply) <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other _____																						
City/Borough				State		Zip Code		School/Center/Camp Name				District Number ____		Phone Numbers Home _____ Cell _____ Work _____																	
Health insurance <input type="checkbox"/> Yes (including Medicaid)? <input type="checkbox"/> No		<input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Foster Parent		Last Name				First Name				Email																			
TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER																															
Birth history (age 0-6 yrs) <input type="checkbox"/> Uncomplicated <input type="checkbox"/> Premature: _____ weeks gestation <input type="checkbox"/> Complicated by _____					Does the child/adolescent have a past or present medical history of the following? <input type="checkbox"/> Asthma (check severity and attach MAF): If persistent, check all current medication(s): Asthma Control Status <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Behavioral/mental health disorder <input type="checkbox"/> Congenital or acquired heart disorder <input type="checkbox"/> Developmental/learning problem <input type="checkbox"/> Diabetes (attach MAF) <input type="checkbox"/> Orthopedic injury/disability Explain all checked items above.																										
Allergies <input type="checkbox"/> None <input type="checkbox"/> Epi pen prescribed <input type="checkbox"/> Drugs (list) _____ <input type="checkbox"/> Foods (list) _____ <input type="checkbox"/> Other (list) _____					<input type="checkbox"/> Intermittent <input type="checkbox"/> Quick Relief Medication <input type="checkbox"/> Well-controlled <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Speech, hearing, or visual impairment <input type="checkbox"/> Tuberculosis (latent infection or disease) <input type="checkbox"/> Hospitalization <input type="checkbox"/> Surgery <input type="checkbox"/> Other (specify) _____ Addendum attached.					<input type="checkbox"/> Mild Persistent <input type="checkbox"/> Inhaled Corticosteroid <input type="checkbox"/> Poorly Controlled or Not Controlled <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Oral Steroid <input type="checkbox"/> Other Controller <input type="checkbox"/> None Medications (attach MAF if in-school medication needed) <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____ _____ _____ _____																					
Attach MAF in in-school medications needed																															
PHYSICAL EXAM Date of Exam: ____/____/____					General Appearance: <input type="checkbox"/> Physical Exam WNL <table><tr><td><i>Ni Abnl</i> <input type="checkbox"/> Psychosocial Development</td><td><i>Ni Abnl</i> <input type="checkbox"/> HEENT</td><td><i>Ni Abnl</i> <input type="checkbox"/> Lymph nodes</td><td><i>Ni Abnl</i> <input type="checkbox"/> Abdomen</td><td><i>Ni Abnl</i> <input type="checkbox"/> Skin</td></tr><tr><td><input type="checkbox"/> Language</td><td><input type="checkbox"/> Dental</td><td><input type="checkbox"/> Lungs</td><td><input type="checkbox"/> Genitourinary</td><td><input type="checkbox"/> Neurological</td></tr><tr><td><input type="checkbox"/> Behavioral</td><td><input type="checkbox"/> Neck</td><td><input type="checkbox"/> Cardiovascular</td><td><input type="checkbox"/> Extremities</td><td><input type="checkbox"/> Back/spine</td></tr></table>												<i>Ni Abnl</i> <input type="checkbox"/> Psychosocial Development	<i>Ni Abnl</i> <input type="checkbox"/> HEENT	<i>Ni Abnl</i> <input type="checkbox"/> Lymph nodes	<i>Ni Abnl</i> <input type="checkbox"/> Abdomen	<i>Ni Abnl</i> <input type="checkbox"/> Skin	<input type="checkbox"/> Language	<input type="checkbox"/> Dental	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Behavioral	<input type="checkbox"/> Neck	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Extremities	<input type="checkbox"/> Back/spine
<i>Ni Abnl</i> <input type="checkbox"/> Psychosocial Development	<i>Ni Abnl</i> <input type="checkbox"/> HEENT	<i>Ni Abnl</i> <input type="checkbox"/> Lymph nodes	<i>Ni Abnl</i> <input type="checkbox"/> Abdomen	<i>Ni Abnl</i> <input type="checkbox"/> Skin																											
<input type="checkbox"/> Language	<input type="checkbox"/> Dental	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological																											
<input type="checkbox"/> Behavioral	<input type="checkbox"/> Neck	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Extremities	<input type="checkbox"/> Back/spine																											
Height _____ cm (____ %ile) Weight _____ kg (____ %ile) BMI _____ kg/m ² (____ %ile) Head Circumference (age ≤2 yrs) _____ cm (____ %ile) Blood Pressure (age ≥3 yrs) _____ / _____					Describe abnormalities:																										
DEVELOPMENTAL (age 0-6 yrs) Validated Screening Tool Used? _____ Date Screened ____/____/____ <input type="checkbox"/> Yes <input type="checkbox"/> No Screening Results: <input type="checkbox"/> WNL <input type="checkbox"/> Delay or Concern Suspected/Confirmed (specify area(s) below): <input type="checkbox"/> Cognitive/Problem Solving <input type="checkbox"/> Adaptive/Self-Help <input type="checkbox"/> Communication/Language <input type="checkbox"/> Gross Motor/Fine Motor <input type="checkbox"/> Social-Emotional or Personal-Social <input type="checkbox"/> Other Area of Concern: _____					Nutrition < 1 year <input type="checkbox"/> Breastfed <input type="checkbox"/> Formula <input type="checkbox"/> Both ≥ 1 year <input type="checkbox"/> Well-balanced <input type="checkbox"/> Needs guidance <input type="checkbox"/> Counseled <input type="checkbox"/> Referred Dietary Restrictions <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____					Hearing Date Done ____/____/____ Results < 4 years: gross hearing ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred OAE ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred ≥ 4 yrs: pure tone audiometry ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred																					
Describe Suspected Delay or Concern: _____					SCREENING TESTS Date Done ____/____/____ Results Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk) ____/____/____ μg/dL ____/____/____ μg/dL					Vision Date Done ____/____/____ Results <3 years: Vision appears: ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl Acuity (required for new entrants and children age 3-7 years) ____/____/____ Right ____/____/____ Left ____/____/____ <input type="checkbox"/> Unable to test																					
					Lead Risk Assessment (annually, age 6 mo-6 yrs) ____/____/____ <input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk					Screened with Glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Strabismus? <input type="checkbox"/> Yes <input type="checkbox"/> No																					
					____ Child Care Only ____					Dental Visible Tooth Decay <input type="checkbox"/> Yes <input type="checkbox"/> No Urgent need for dental referral (pain, swelling, infection) <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Visit within the past 12 months <input type="checkbox"/> Yes <input type="checkbox"/> No																					
					Hemoglobin or Hematocrit ____/____/____ _____ g/dL _____%																										
Child Receives EI/CPSE/CSE services <input type="checkbox"/> Yes <input type="checkbox"/> No					CIR Number _____ Physician Confirmed History of Varicella Infection <input type="checkbox"/> Report only positive immunity:																										
IMMUNIZATIONS – DATES																															
DTP/DTaP/DT _____ Tdap _____												IgG Titers Date																			
Td _____ MMR _____												Hepatitis B _____																			
Polio _____ Varicella _____												Measles _____																			
Hep B _____ Mening ACWY _____												Mumps _____																			
Hib _____ Hep A _____												Rubella _____																			
PCV _____ Rotavirus _____												Varicella _____																			
Influenza _____ Mening B _____												Polio 1 _____																			
HPV _____ Other _____												Polio 2 _____																			
												Polio 3 _____																			
ASSESSMENT <input type="checkbox"/> Well Child (Z00.129) <input type="checkbox"/> Diagnoses/Problems (list) _____ ICD-10 Code _____					RECOMMENDATIONS <input type="checkbox"/> Full physical activity <input type="checkbox"/> Restrictions (specify) _____ Follow-up Needed <input type="checkbox"/> No <input type="checkbox"/> Yes, for _____ Appt. date: ____/____/____ Referral(s): <input type="checkbox"/> None <input type="checkbox"/> Early Intervention <input type="checkbox"/> IEP <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other _____																										
Health Care Practitioner Signature					Date Form Completed ____/____/____					DOHMH ONLY		PRACTITIONER I.D. _____																			
Health Care Practitioner Name and Degree (print)					Practitioner License No. and State					TYPE OF EXAM: <input type="checkbox"/> NAE Current <input type="checkbox"/> NAE Prior Year(s) Comments: _____																					
Facility Name					National Provider Identifier (NPI)					Date Reviewed: ____/____/____ I.D. NUMBER _____																					
Address					City					State					Zip		REVIEWER: _____														
Telephone			Fax		Email			FORM ID# _____																							

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