BRONX COMMUNITY COLLEGE

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.
- ✓ Proof of Address : State ID, NYC ID, Utility Bill, Government issued Mail
- ✓ Child's Current Medical Record (must be completed by doctor)
- ✓ Immunization Card/ Printout of Immunizations with Influenza
- ✓ Original Child's Birth Certificate (Copies not accepted)
- ✓ Class Schedule from CUNYFirst with Name and EMPLID ID and Education Verification
- ✓ BCC Student 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 by 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 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 such as Breakfast, Lunch, and snack for the children daily.

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 and List of Immunizations– 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 Student Identification Card**
- **Proof of Address : State ID, NYC ID, Utility Bill, Government Issued Mail**
- **Child's Birth Certificate (Original only)**
- **Your Complete Class Schedule and Education Verification from CUNYFirst**

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 _____ **Primary Language:**_____

EMPLID ID_____

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

Email:
_____

Estimated Graduation year
_____

Race:_____

Are you Latino/Hispanic?
YES/NO

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:**_____ **X:**_____

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

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

Parental Info.	Parent #1/Guardian	Parent #2/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 $_____.

_____ _____
Administrator **Date**
BCC Early Childhood Center

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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:

a. Contact student-parent on campus.
b. Contact persons listed on emergency form/card submitted to the Center.
c. Obtain emergency medical care or referral from the Bronx Community College Health Services Center.
d. Transportation by emergency medical vehicle to nearest hospital.
e. **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.

SIGN: _____ **DATE:** _____

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FAMILY/SOCIAL/DEVELOPMENTAL HISTORY

Child's Name_____ **Date of Birth**_____

Parent #1/Guardian _____**D.O.B:** _____
(Include Maiden Name)

Address_____
_____ **Telephone #**_____

Occupation _____ **Birthplace** _____

Parent #2/Guardian_____**D.O.B:**_____

Address _____
_____ **Telephone #** _____

Occupation _____ **Birthplace**_____

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)

Are Birth Parent's 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? _____

Please continue to page 2

Is your child receiving special services? Check One (OT, PT, Speech , ABA)? _____YES _____ NO

(If yes, please attach your Child's IEP)

Social / Developmental History:

At what age did your child: Walk? _____ Talk in simple sentences? _____

Became 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

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

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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 10:00am-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.

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.

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

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

_____ _____ _____
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

English

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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.

CACFP
Child and Adult Care Food Program
New York State Department of Health

INCOME ELIGIBILITY FORM
for Child Care Centers

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

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 A

Food Stamp Case Number _____

TANF Number _____

FDPIR Number _____

Names of Foster Children _____

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.

I certify that the above information is true. I understand that the center will get Federal funds based on the information I give.

Signature: _____

Date: _____

FOR SPONSOR USE ONLY

Sponsor Agreement Number _____

Total Household Members _____
(including foster children, if applicable)

Total Income $_____

Free _____ Reduced _____ Paid _____

Date Determined _____ / _____ / _____

Signature of Center Staff _____

SECTION B

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.

Name of Household Members	Monthly Gross Income
1. _____	$ _____
2. _____	$ _____
3. _____	$ _____
4. _____	$ _____
5. _____	$ _____
6. _____	$ _____

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.

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.

Signature: _____

Print Name: _____

SS# XXX-XX-__ __ __ __ Date: _____

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** ☐ Female ☐ Male | **Date of Birth** *(Month/Day/Year)* ___ ___ / ___ ___ / ___ ___ ___ ___

Child's Address | **Hispanic/Latino?** ☐ Yes ☐ No | **Race** *(Check ALL that apply)* ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other _____

City/Borough | **State** | **Zip Code** | **School/Center/Camp Name** *Bronx Community College Early Childhood Center* | **District Number** __ _10_ _ __ | **Phone Numbers** Home _____ Cell _____ Work _____

Health insurance (including Medicaid)? ☐ Yes ☐ No | ☐ **Parent/Guardian** ☐ **Foster Parent** **Last Name** **First Name** | **Email**

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* _____

☐ Foods *(list)* _____

☐ Other *(list)* _____

Attach MAF in in-school medications needed

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma ***(check severity and attach MAF)***: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None

Asthma Control Status ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis
☐ Behavioral/mental health disorder
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes ***(attach MAF)***
☐ Orthopedic injury/disability
Explain all checked items above.

☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) _____
☐ ***Addendum attached.***

Medications ***(attach MAF if in-school medication needed)***

☐ None ☐ Yes *(list below)*

_____
_____
_____
_____

PHYSICAL EXAM **Date of Exam:** ___ /___ /___

Height _____ **cm** (___ ___ %ile)

Weight _____ **kg** (___ ___ %ile)

BMI _____ **kg/m²** (___ ___ %ile)

Head Circumference *(age ≤2 yrs)* _____ **cm** (___ ___ %ile)

Blood Pressure *(age ≥3 yrs)* _____ / _____

General Appearance:

☐ Physical Exam WNL

	Nl Abnl		*Nl Abnl*		*Nl Abnl*		*Nl Abnl*
	☐ ☐ Psychosocial Development	☐ ☐ HEENT		☐ ☐ Lymph nodes		☐ ☐ Abdomen		☐ ☐ Skin
	☐ ☐ Language	☐ ☐ Dental		☐ ☐ Lungs		☐ ☐ Genitourinary		☐ ☐ Neurological
	☐ ☐ Behavioral	☐ ☐ Neck		☐ ☐ Cardiovascular		☐ ☐ Extremities		☐ ☐ Back/spine

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)*

Validated Screening Tool Used? ☐ Yes ☐ No

Date Screened ___/___/___

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help
☐ Communication/Language ☐ Gross Motor/Fine Motor
☐ Social-Emotional or Personal-Social ☐ Other Area of Concern: _____

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< 1 year ☐ Breastfed ☐ Formula ☐ Both

≥ 1 year ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred

Dietary Restrictions ☐ None ☐ Yes *(list below)*

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
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	___/___/___	☐ At risk *(do BLL)* ☐ Not at risk
—— Child Care Only ——		
Hemoglobin or Hematocrit	___/___/___	_____ g/dL _____ %

Hearing

	Date Done	*Results*
< 4 years: gross hearing	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*
OAE	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*
≥ 4 yrs: pure tone audiometry	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*

Vision

	Date Done	*Results*
<3 years: Vision appears:	___/___/___	☐ *Nl* ☐ *Abnl*
Acuity (required for new entrants and children age 3-7 years)	___/___/___	Right _____ /_____ Left _____ /_____ ☐ Unable to test
Screened with Glasses?		☐ Yes ☐ No
Strabismus?		☐ Yes ☐ No

Dental

Visible Tooth Decay	☐ Yes ☐ No
Urgent need for dental referral *(pain, swelling, infection)*	☐ Yes ☐ No
Dental Visit within the past 12 months	☐ Yes ☐ No

CIR Number

Physician Confirmed History of Varicella Infection ☐

Report only positive immunity:

IMMUNIZATIONS – DATES

DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	

Tdap	___/___/___	___/___/___	___/___/___						
MMR	___/___/___	___/___/___	___/___/___						
Varicella	___/___/___	___/___/___	___/___/___						
Mening ACWY	___/___/___	___/___/___	___/___/___						
Hep A	___/___/___	___/___/___	___/___/___						
Rotavirus	___/___/___	___/___/___	___/___/___						
Mening B	___/___/___	___/___/___	___/___/___						
Other _____	___/___/___	_____	___/___/___						

	IgG Titers	Date
Hepatitis B		___/___/___
Measles		___/___/___
Mumps		___/___/___
Rubella		___/___/___
Varicella		___/___/___
Polio 1		___/___/___
Polio 2		___/___/___
Polio 3		___/___/___

ASSESSMENT ☐ **Well Child** (Z00.129) ☐ **Diagnoses/Problems** *(list)* **ICD-10 Code**

_____ _____
_____ _____
_____ _____

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions (*specify*) _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: __ __/__ __/__ __

Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision

☐ 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: ☐ NAE Current ☐ NAE Prior Year(s)

Comments:

Facility Name | National Provider Identifier (NPI)

Date Reviewed: ___/___/___ **I.D. NUMBER**

REVIEWER:

Address | City | State | Zip

Telephone | Fax | Email

FORM ID#