St. Mark's Day Care Center, Inc.
Child Care Enrollment Profiles
(Includes Family Health Data Instruments)

368-70 Newfield Avenue
Bridgeport CT 06607
Tel: (203) 335-3828 / Fax: (203) 335-4344

A Full Day (6:30am–5:30pm) Comprehensive Infant Care, Pre-School, After School, and Family Support Program

1 Children ages 6 weeks to 12 years

2 Professional Certified Staff

3 Child Nutrition Program

4 Optional Payment Schedule w/Sliding Fee

5 Summer School Age Program

6 Parent Resources

7 Family Counseling

8 Health Screening
Dental ~ Hearing ~ Lead ~ Vision

REVISED: MARCH 1, 2021

ST. MARK'S DAY CARE CENTER, INC.
ENROLLMENT CHECKLIST
(FOR OFFICE USE ONLY)

- ***$25 Non-Refundable Application Fee due at Drop off***
- Signed Application
- Picture ID – (CT-DL/ID Card, Passport)
- Signed Fee Agreement ***(Care4Kids recipient pays full fee per week until Care4Kids approval)***
- Sign that Parent Received Handbook
- ***Physical and Immunization records (Must be seen by Nurse Consultant before admission)***
- ***Proof of Address - Utility Bill***
- Complete Nutrition Eligibility Form (signed)
- ***Social Security Card (Child and Parent)***
- ***Birth Certificate***
- Budget letter (D.S.S I.D. Card)
- Child Support Proof (Statement or Court Order)
- ***4 Paycheck Stubs (present/previous Tax Return)***
- Certificate of Confirmation for Care4Kids.
- ***Job Confirmation (for parents starting work)***
- Distributed Parent Handbook
- Parents Statement of Agreement

Child's Start Date _____ *pending the appropriate documents are in place.*

Day Care Fee $_____

FOR OFFICE USE ONLY

Date Application was received ____/_____/_____

Verification of DOB - Date ____/_____/_____ Interviewer_____

Verification of Income - Date ____/_____/_____Interviewer_____

Admissions_____ Re-determination_____

Hours of Attendance From ____: ____A.M. to ____: _____P.M.

DCF Number_____ Referral Date Indicator_____

Date of Admissions _____/_____/_____

Date of Transfer _____/_____/_____

Date of Termination _____/_____/_____

Date of Graduation _____/_____/_____

ST. MARK'S DAY CARE CENTER, INC.
ENROLLMENT CHECKLIST

TO: Parent(s) FROM: Ms. Tenisha Holeyfield, Intake Coordinator

Please initial after completing enrollment form indicating that you have read, understood and signed the required forms in this registration packet.

Parent's Name_____

Child's Name _____

- Child Care Information Sheet _____
- Application for child care/family household information _____
- Child care emergency information form _____
- Child health records _____
- Vaccine preventable childhood diseases _____
- Emergency medical plan _____
- Authorized pick-up list _____
- Authorized administration of non-prescription _____
- Parents memo/St. Mark's Day Care Nurse Consultant _____
- Permission slip to walk children to school/neighborhood walks _____
- Income eligibility forms _____
- Parent information form _____
- Parent's statement of agreement _____
- PARENT ENROLLMENT CHECKLIST _____
- PARENT HANDBOOK AND SIGNATURE _____

_____ _____

Parent's Signature Date

ST. MARK'S DAY CARE CENTER, INC.
Child Care Information Sheet

Thank you for expressing an interest in our programs. The St. Mark's Day Care Center is located at 368-70 Newfield Avenue, Bridgeport, Connecticut 06607. Our telephone number is (203) 335-3828 and our fax number is (203) 335-4344.

The Center's *Administrative Offices* are open Monday through Friday, 8:30am - 5:30pm.

St. Mark's Day Care Center provides a number of services to the Greater Bridgeport Community. These services include:

Day Care Services for:

- Infants - Toddlers
- Pre School Children
- School Age Children (Before and After School Program)
- Parenting/Literacy Program for Adults (Referral)
- SMDCC Summer Camp (Summer daycare program designed for students ages 6 to 12yrs)

Some fees for daycare services are computed on: a sliding standard fee scale supported by the State of Connecticut Department of Social Services. Private Day Care fees are also available. Fees are based on gross annual income and the number of dependents per household.

The day care program operates five days a week - Monday through Friday on a year round basis. The Center is open from 6:30a.m. to 5:30p.m. and provides guidance, educational and motivational activities. Two nutritious meals and a snack are served during operating hours under the auspices of the State of Connecticut Child Care Food Program and are free to participants.

Attached you will find:

1. **Application** - Please be sure all questions are answered; that the application is signed by parent or legal guardian, and that verification of income is attached. (i.e. pay stub, State budget sheet or W-2 form). Income verification must be current; not more than one month old.
2. **Health Form** - Please take the Child Health Care Record Form to your child's doctor. This completed form must be submitted with your application. ***All areas must be filled in or we cannot accept the form.*** If you do not have a physician, contact the center's social service office for assistance.

   Please return this completed application package to the Enrollment Coordinator at the day care center.

APPLICATION FOR CHILD CARE

ST. MARK'S DAY CARE CENTER, INC.
368-70 NEWFIELD AVENUE
BRIGEPORT, CONNECTICUT 06607
PHONE: (203) 335-3828 FAX: (203) 335-4344

PLEASE PRINT *(BLUE OR BLACK INK ONLY)* DATE OF APPLICATION ___/___/____

Name of Child _____
(Last) (First) (Middle) (Nickname)

Date of Birth _____ Place of Birth _____ Sex _____
Please Check: Black_____ White_____ Hispanic _____ Native American _____ Other _____

Home Address: _____
(Street)

_____
(City) (State) (Zip Code)

Home Telephone Number: (_____) _____

Child Lives with: Both Parents_____ Mother_____ Father_____ Other_____
I am this child's: Natural Parent_____ Grand Parent_____ Foster Parent_____

Name of Case Worker_____ *Court Appointed Legal Guardian_____

***PLEASE ATTACH COPY OF GUARDIANSHIP PAPERS FROM THE COURTS**

FAMILY HOUSEHOLD INFORMATION

Mother's Name:_____ Social Security Number _____ -_____-_____

Mother's Address:_____Phone: _____-_____-_____

Place of Employment: _____Email:_____

Employer's Address: _____

Phone: _____-_____-_____ Working Hours: ____:____AM to _____:____PM

Father's Name:_____ Social Security Number _____ -____-_____

Father's Address:_____Phone:____-_____-_____

Place of Employment: _____Email:_____

Employer's Address: _____

Phone: _____-_____-_____ Working Hours: ____:____AM to _____:_____PM

Name of Guardian if other than Mother or Father_____
Language spoken at home? _____ Annual Income _____
Are you attending school - __Y __N Hours needed for Child Care: From:-____AM to ____PM
NOTE: CHILD CARE HOURS ARE PROVIDED ACCORDING TO YOUR WORK SCHEDULE.

ST. MARK'S DAY CARE CENTER, INC.

PARENT INFORMATION FORM

To make the St. Mark's Child Care Programs as exciting and supportive for the children and families involved, it will be helpful for the Board and staff to know what types of skills parents might be willing to share, how they might be involved in the program, and what resources they or their employers might be willing to share. Please answer the questions below and return the sheet. THANK YOU!

1. Parent Name _____ Child's Name: _____
2. Telephone Numbers: Home _____ Work _____ Cell _____
3. Is it okay to call you at work? _____ Yes _____ No Email _____
4. What is the most convenient time to call? _____
5. Who is your employer? _____
6. Do they have a program to support volunteer efforts of employees? _____ Yes _____ No
7. What other organizations, if any, do you belong to? _____
8. Have you had experience as a Board of Director? _____ Yes _____ No
9. Do you have any skills you would be willing to share? _____
10. In what way would you be willing to contribute to SMDCC's child care program? _____

Some possible ways are:

1. Planning family activities
2. Serving on a committee
3. Shopping for supplies
4. Serving as a Board of Directors
5. Having children visit workplace to learn about jobs and work
6. Sharing a skill with the children
7. Other:

A copy of this form will be given to Unit Staff.

Assigned Unit _____ Parent Signature _____ Date _____

ST. MARK'S DAY CARE CENTER, INC.

HEALTH CARE PROCEDURES

St. Mark's Day Care Nurse Consultant.

The following are some health guidelines to keep illnesses at a minimum:

PLEASE KEEP YOUR CHILD AT HOME IF:

1. He/she has *not* been fever free for 24 hours - 100 or higher
2. He/she has thrown up twice within ten hours
3. He/she has had three loose/watery bowel movements within six hours.
4. Been in contact with or exposed to COVID positive person for up to 10 days.

WE WILL SEND YOUR CHILD HOME IF:

1. He/she has a fever of at least 100 degrees F.
2. He/she vomits and does not feel well.
3. He/she has 3 loose/watery stools within the last 4-6 hours. Parent will be notified of the situation after first loose bowel movement. The child need not be excluded unless parent decides, or above criteria is met.
4. He/she is not feeling well and the child is unable to participate in the program. This decision will be determined by the child's teacher *and* administrative staff. An administrative staff must be notified before sending a child home, i.e., Head Teacher, Unit Supervisor, Executive Director, Nurse Consultant, and Intake Coordinator.
5. He/she has lice infestation.
6. He/she has symptoms of a contagious condition (i.e., conjunctivitis (pink-eye), impetigo, or ringworm.
7. In order for the child to return to the program, the parent must have a note from the Doctor indicating that the child is not contagious or the prescribed treatment for the contagious condition has been given to the child for at least a twenty-four hour period. For example, if a child is sent home on Tuesday, and has been receiving medication for at least 24 hours, he/she can return on Thursday with the Doctor's note.

Medicine *(prescription or over the counter)* cannot be given in the center unless the parent or designated adult with written permission comes in and gives it to the child.

IF YOU BECOME AWARE OF ANY PHYSICAL OR EMOTIONAL HEALTH PROBLEM THAT YOUR CHILD MAY HAVE, PLEASE LET US KNOW RIGHT AWAY. IF YOU HAVE ANY QUESTIONS, IN WHICH THE CENTER'S HEALTH PROFESSIONAL CAN/MAY BE ABLE TO HELP YOU, PLEASE DO NOT HESITATE TO ASK US.

ST. MARK'S DAY CARE CENTER, INC.

Health Evaluation Requirement

ATTENTION: PARENT(S):

IN ORDER FOR YOUR CHILD TO BE ENROLLED OR ADMITTED INTO THE CENTER, THE CHILD'S PHYSICIAN ***MUST*** COMPLETE THE ***REQUIRED*** STATE OF CONNECTICUT PHYSICAL FORM AND CHILD'S IMMUNIZATIONS MUST BE CURRENT.

ATTACHED IS THE REQUIRED HEALTH EVALUATION FORM TO BE COMPLETED BY THE CHILD'S PHYSICIAN.

FOR HEALTH EVALUATION UPDATES, SPEAK WITH THE CENTER'S PROGRAM HEALTH CONSULTANT, INTAKE COORDINATOR, OR HEAD TEACHER.

State of Connecticut Department of Education
Early Childhood Health Assessment Record
(For children ages birth–5)

To Parent or Guardian: In order to provide the best experience, early childhood providers must understand your child's health needs. This form requests information from you (Part 1) which will be helpful to the health care provider when he or she completes the health evaluation (Part 2) and oral health assessment (Part 3). State law requires complete primary immunizations and a health assessment by a physician, an advanced practice registered nurse, a physician assistant, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to entering an early childhood program in Connecticut.

Please print

Child's Name (Last, First, Middle)	Birth Date (mm/dd/yyyy)	☐Male ☐Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
Early Childhood Program (Name and Phone Number)	Race/Ethnicity ☐American Indian/Alaska Native ☐Native Hawaiian/Pacific Islander ☐Asian ☐White ☐Black or African American ☐Other ☐Hispanic/Latino of any race	
Primary Health Care Provider: Name of Dentist:		
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance? Y N
Does your child have dental insurance? Y N
Does your child have HUSKY insurance? Y N

If your child does not have health insurance, call **1-877-CT-HUSKY**

* If applicable

Part 1 — To be completed by parent/guardian.
Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Frequent ear infections	Y	N	Asthma treatment	Y	N
Allergies to food, bee stings, insects	Y	N	Any speech issues	Y	N	Seizure	Y	N
Allergies to medication	Y	N	Any problems with teeth	Y	N	Diabetes	Y	N
Any other allergies	Y	N	Has your child had a dental			Any heart problems	Y	N
Any daily/ongoing medications	Y	N	examination in the last 6 months?	Y	N	Emergency room visits	Y	N
Any problems with vision	Y	N	Very high or low activity level	Y	N	Any major illness or injury	Y	N
Uses contacts or glasses	Y	N	Weight concerns	Y	N	Any operations/surgeries	Y	N
Any hearing concerns	Y	N	Problems breathing or coughing	Y	N	Lead concerns/poisoning	Y	N
Developmental — Any concern about your child's:						Sleeping concerns	Y	N
1. Physical development	Y	N	5. Ability to communicate needs	Y	N	High blood pressure	Y	N
2. Movement from one place			6. Interaction with others	Y	N	Eating concerns	Y	N
to another	Y	N	7. Behavior	Y	N	Toileting concerns	Y	N
3. Social development	Y	N	8. Ability to understand	Y	N	Birth to 3 services	Y	N
4. Emotional development	Y	N	9. Ability to use their hands	Y	N	Preschool Special Education	Y	N

Explain all "yes" answers or provide any additional information:

Have you talked with your child's primary health care provider about any of the above concerns? Y N

Please list any medications your child will need to take during program hours:

All medications taken in child care programs require a separate Medication Authorization Form signed by an authorized prescriber and parent/guardian.

I give my consent for my child's health care provider and early childhood provider or health/nurse consultant/coordinator to discuss the information on this form for confidential use in meeting my child's health and educational needs in the early childhood program.

Signature of Parent/Guardian Date

Part 2 — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation, physical examination and immunization record.

Child's Name _____ Birth Date _____ (mm/dd/yyyy) Date of Exam _____ (mm/dd/yyyy)

☐ I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider.

*HT____in/cm____% *Weight____lbs.____oz /____% BMI____/____% *HC____in/cm____% (Birth–24 months) *Blood Pressure____/____ (Annually at 3–5 years)

Screenings

***Vision Screening**
- ☐ EPSDT Subjective Screen Completed (Birth to 3 yrs.)
- ☐ EPSDT Annually at 3 yrs. (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

☐ Unable to assess
☐ Referral made to: _____

***Hearing Screening**
- ☐ EPSDT Subjective Screen Completed (Birth to 4 yrs.)
- ☐ EPSDT Annually at 4 yrs. (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
	☐ Pass	☐ Pass
	☐ Fail	☐ Fail

☐ Unable to assess
☐ Referral made to: _____

***Anemia:** at 9 to 12 months and 2 years

***Hgb/Hct:** | ***Date**

***Lead:** at 1 and 2 years; if no result screen between 25 – 72 months

History of Lead level
≥ 5µg/dL ☐ No ☐ Yes

***TB:** High-risk group? ☐ No ☐ Yes
Test done: ☐ No ☐ Yes Date: _____
Results: _____
Treatment: _____

***Dental Concerns** ☐ No ☐ Yes
☐ Referral made to: _____
Has this child received dental care in the last 6 months? ☐ No ☐ Yes

***Result/Level:** ***Date**

Other:

***Developmental Assessment:** (Birth–5 years) ☐ No ☐ Yes **Type:**

Results:

***IMMUNIZATIONS** ☐ Up to Date or ☐ Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

Asthma ☐ No ☐ Yes: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent ☐ Exercise induced
If yes, please provide a copy of an Asthma Action Plan
☐ Rescue medication required in child care setting: ☐ No ☐ Yes

Allergies ☐ No ☐ Yes: _____
Epi Pen required: ☐ No ☐ Yes
History/risk of Anaphylaxis: ☐ No ☐ Yes: ☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Unknown source
If yes, please provide a copy of the Emergency Allergy Plan

Diabetes ☐ No ☐ Yes: ☐ Type I ☐ Type II
Seizures ☐ No ☐ Yes: Type: _____
Other Chronic Disease: _____

☐ This child has the following problems which may adversely affect his or her educational experience:
☐ Vision ☐ Auditory ☐ Speech/Language ☐ Physical ☐ Emotional/Social ☐ Behavior

☐ This child has a developmental delay/disability that may require intervention at the program.

☐ This child has a special health care need which may require intervention at the program, e.g., special diet, long-term/ongoing/daily/emergency medication, history of contagious disease. *Specify:* _____

☐ No ☐ Yes This child has a medical or emotional illness/disorder that now poses a risk to other children or affects his/her ability to participate safely in the program.

☐ No ☐ Yes Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.

☐ No ☐ Yes This child may fully participate in the program.

☐ No ☐ Yes This child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.)

_____

☐ No ☐ Yes Is this the child's medical home? ☐ I would like to discuss information in this report with the early childhood provider and/or nurse/health consultant/coordinator.

_____

Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped *Provider* Name and Phone Number

Part 3 — Oral Health Assessment/Screening

Health Care Provider must complete and sign the oral health assessment.

To Parent(s) or Guardian(s):
State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

Student Name (Last, First, Middle)	Birth Date	Date of Exam
School	Grade	☐Male ☐Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination	**Visual Screening**	Normal	**Referral Made:**
Completed by: ☐Dentist	Completed by: ☐MD/DO ☐APRN ☐PA ☐Dental Hygienist	☐Yes ☐Abnormal (Describe) _____ _____ _____ _____ _____	☐Yes ☐No

Risk Assessment	**Describe Risk Factors**	
☐Low	☐Dental or orthodontic appliance	☐Carious lesions
☐Moderate	☐Saliva	☐Restorations
☐High	☐Gingival condition	☐Pain
	☐Visible plaque	☐Swelling
	☐Tooth demineralization	☐Trauma
	☐Other _____	☐Other _____

Recommendation(s) by health care provider: _____

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

Signature of Parent/Guardian Date

Signature of health care provider	DMD / DDS / MD / DO / APRN / PA/ RDH	Date Signed	Printed/Stamped *Provider* Name and Phone Number

Child's Name: _____ Birth Date: _____ REV. 10/2018

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) _____

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP/DT						
IPV/OPV						
MMR						
Measles						
Mumps						
Rubella						
Hib						
Hepatitis A						
Hepatitis B						
Varicella						
PCV* vaccine					*Pneumococcal conjugate vaccine	
Rotavirus						
MCV**					**Meningococcal conjugate vaccine	
Flu						
Other						

Disease history for varicella (chickenpox) _____
(Date) (Confirmed by)

Exemption: Religious _____ Medical: Permanent _____ †Temporary _____ Date _____
†Recertify Date _____ †Recertify Date _____ †Recertify Date _____

Immunization Requirements for Connecticut Day Care, Family Day Care and Group Day Care Homes

Vaccines	Under 2 months of age	By 3 months of age	By 5 months of age	By 7 months of age	By 16 months of age	16–18 months of age	By 19 months of age	2–3 years of age (24-35 mos.)	3–5 years of age (36-59 mos.)
DTP/DTaP/ DT	None	1 dose	2 doses	3 doses	3 doses	3 doses	4 doses	4 doses	4 doses
Polio	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
MMR	None	None	None	None	1 dose after 1st birthday[4]	1 dose after 1st birthday[4]	1 dose after 1st birthday[4]	1 dose after 1st birthday[4]	1 dose after 1st birthday[4]
Hep B	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
HIB	None	1 dose	2 doses	2 or 3 doses depending on vaccine given[3]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]
Varicella	None	None	None	None	None	None	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]
Pneumococcal Conjugate Vaccine (PCV)	None	1 dose	2 doses	3 doses	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday
Hepatitis A	None	None	None	None	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	2 doses given 6 months apart[5]	2 doses given 6 months apart[5]
Influenza	None	None	None	1 or 2 doses	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]

1. Laboratory confirmed immunity also acceptable
2. Physician diagnosis of disease
3. A complete primary series is 2 doses of PRP-OMP (PedvaxHIB) or 3 doses of HbOC (ActHib or Pentacel)
4. As a final booster dose if the child completed the primary series before age 12 months. Children who receive the first dose of Hib on or after 12 months of age and before 15 months of age are required to have 2 doses. Children who received the first dose of Hib vaccine on or after 15 months of age are required to have only one dose
5. Hepatitis A is required for all children born after January 1, 2009
6. Two doses in the same flu season are required for children who have not previously received an influenza vaccination, with a single dose required during subsequent seasons

_____

Initial/Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped *Provider* Name and Phone Number

ST. MARK'S DAY CARE CENTER, INC.
Vaccine - Preventable Childhood Diseases

The following vaccinations are needed by age 2 and can be given in five visits to a doctor or clinic:

- 4 vaccinations against Diphthaeria, Tetanus and Pertussia (DTP)
- 3 vaccinations against Polio
- 1 vaccination against Measles/Mumps/Rubella (MMR)
- 3 - 4 vaccinations against Hib
- 3 vaccinations against Hepatitis B
- 1 vaccination against Varicella

If a child is behind in his/her immunization series, he/she does not have to start over again. Following, is information about diseases these immunizations prevent.

POLIO

Polio is caused by a virus which is spread by contact with the feces (bowel movement) of an infected person. Symptoms can include a sudden fever, sore throat, headache, muscle weakness and pain. Polio can cause paralysis and death.

DIPTHERIA

Diptheria is spread when germs pass from an infected person or carrier to the nose or throat of others. It is a very serious disease which can block the airway, making it impossible to breath. It can also cause heart problems. Five to 10 out of 100 people who get diphtheria die.

TETANUS (lock jaw)

Tetanus is caused by a toxin produced by a germ that inters the body through a cut or wound. Tetanus causes serious, painful spasm of all muscles, and can lead to "locking" of the jaw so a person cannot open his or her mouth, swallow or breathe. Three out of 10 people who get tetanus die.

PERTUSSIS (whooping cough)

Pertussis is easily spread when germs pass from an infected person to the nose or throat of others. Pertussis can cause spells of violent coughing and choking, making it hard to breathe, drink or eat. The cough can last for weeks. This disease is most serious for babies. Babies can get pneumonia, have seizures, become brain damage or even die. About half of the babies who get pertussis have to go to the hospital. There are pertussis outbreaks every year because children are not immunized. About half of the babies who get pertussis have to go to the hospital. There are pertussis outbreaks every year because children are not immunized.

AGE APPROPRIATE
IMMUNIZATION REQUIREMENTS

FOR IMMUNIZATION QUESTIONS ONLY, CALL 1-860-509-7929

CHILD'S AGE	IMMUNIZATION(S)
Birth – 2 months	Hep B #1 (hepatitis B)
1-4 months	Hep B #2 – at least 1 month after Hep B #1
2 months	DtaP/DT #1 (diphtheria, tetanus and acellular pertussis), IPV #1 (polio), Hib #1 (Haemophilus influenzae type b), PCV #1 (Pneumococcal Conjugate-recommended)
4 months	DtaP/DT #2, IPV #2, Hib #2, PCV #2 (recommended)
6 months	DtaP/DT #3, Hib #3, PCV #3 (recommended)
6-18 months	Hep B#3, IPV #3
12-15 months	Hib #4, MMR #1 (measles, mumps and rubella), PCV #4 (recommended)
12-18 months	Varicella (chickenpox vaccine) for children born after December 31, 1996)
15-18 months	DtaP/DT #4-DtaP/Hib may be combined as TriHibit
Before starting school (4-6 years)	DtaP/DT #5, IPV #4, MMR #2

- Effective January 1, 2002, varivax (varicella/chickenpox) vaccine is required for all enrolled children born after December 31, 1996.

Required Immunizations – Must be given by the end of the stated month of life listed under "CHILD'S AGE". For example, immunizations required at two months must be given prior to the child turning three months in order for the child to continue in the program.

Your signature indicates you have read and received the Immunizations Requirements outlined above.

_____ _____

Parent Signature Date

ST. MARK'S DAY CARE CENTER, INC.

CHILD CARE EMERGENCY INFORMATION FORM

CHILD'S NAME _____

ADDRESS _____

HOME TELEPHONE NUMBER _____ _____

MOTHER'S/FATHER'S NAME _____

WORKPLACE _____

ADDRESS _____

WORK HOURS _____

WORK TELEPHONE NUMBER _____

ALLERGIES _____

SIGNIFICANT HEALTH HISTORY _____

_____

_____

DATE OF LAST TETANUS SHOT _____

PHYSICIAN _____ TELEPHONE _____

DENTIST _____ TELEPHONE _____

HOSPITAL PREFERENCE _____

HEALTH INSURANCE _____ INSURANCE # _____

ST. MARK'S DAY CARE CENTER, INC.

PARENT / GUARDIAN AUTHORIZATION FOR THE ADMINISTRATION OF NON-PRESCRIPTION TOPICAL MEDICATIONS BY DAY CARE PERSONNEL

To: Present Child Care Nurse Consultant, Director and/or Teacher:

I hereby request that the following non-prescription topical medication be administered to my child by a staff member of the day care facility. I understand that I must supply the child day care center or group day care home with the non-prescription topical medication in the original container, labeled with the child's name, the name of the medication, and the medication application directions.

This authorization is limited to the following topical medications:

1. Non-prescription diaper changing ointments that are free of antibiotic or steroidal components.
2. Non-prescription insect repellents.
3. Non-prescription teething medications.
4. Non-prescription sunscreen protectants that are free of amino benzoic acid (BABA) or its derivatives.

Name of Child _____ Date of Birth _____
Address _____
Medication: Name, method of administrative, area of application _____
_____
Schedule of Administration _____
Medication shall be administered from _____ to _____
(Date) (Date)
Reason for which medication is being administered_____

I have administered at least one dose of the above medication to my child without adverse side effects.

Name of Parent / Guardian _____ Date _____
Signature _____ Relationship to Child _____
Address _____Phone_____

FOR STAFF TO COMPLETE

Parent authorization form and medication received by:_____(signature of staff)

Medication started _____ (date/time) Medication ended _____ (date/time)

ST. MARK'S DAY CARE CENTER, INC.

EMERGENCY MEDICAL PLAN

****

In an emergency, staff will take whatever steps necessary to obtain emergency medical care if warranted.

These steps include:

1. Administer first aid.
2. Attempt to contact parent or guardian.
3. Attempt to contact the parent through any of the persons listed in the pick-up listing. ***(NOTE: It is the parents' responsibility to keep this information up to date)***.
4. If we cannot contact the parent or physician, we will do any or all of the following:
    a. Call an ambulance; and
    b. Have the child taken to the nearest hospital, or the hospital of the parent/guardian's choice, in the company of a staff member via ambulance or police vehicle.
5. A copy of the child's most recent physical with the child's insurance information will be taken to the hospital. It is the responsibility of the parent/guardian upon hospital arrival to ensure that all insurance information given to the registration department is correct.
6. Any expenses incurred under #4 and #5 above, will be the responsibility of the child's parent or guardian.
7. In the event that a classroom staff member is needed to accompany a child to the hospital, an alternate staff member will cover the classroom.

I give consent for implementation of the above plan.

_____ _____

Parent or Guardian (print) Date

_____

Parent or Guardian (signature)

ST. MARK'S DAY CARE CENTER, INC.
First Aid for Dental Emergencies

In the event of a dental emergency, staff will take whatever steps necessary to obtain emergency medical care if warranted.

In the event of a Dental Emergency the Center will:

1. Administer the correct Dental First Aid as listed above for the appropriate emergency.

2. Attempt to contact the parent/guardian immediately.

3. Attempt to contact the parent/guardian through any of the persons listed in the emergency pick up listing, in the event that we are unable to contact the parent/guardian.

4. If we cannot reach the parent, we will do any or all of the following:
   - Call an ambulance
   - Have the child taken to the nearest hospital, or the hospital of the parent/guardian's choice, in the company of a staff member via ambulance or police vehicle.

5. A copy of the child's most recent physical with the child's insurance information will be taken to the hospital. It is the responsibility of the parent/guardian upon hospital arrival to ensure that all insurance information given to the registration department is correct.

6. In the event that a classroom staff member is needed to accompany a child to the hospital, an alternate staff member will cover the classroom.

7. Any expenses incurred under #4 and #5 above, will be the responsibility of the child's parent/guardian.

It is the responsibility of the parent/guardian to keep the emergency information up to date.

I give consent for the implementation of the above Dental Emergency Plan.

_____ _____

Parent/Guardian (print) Date

_____

Parent Guardian (signature)

ST. MARK'S DAY CARE CENTER, INC.

CHLD MEDICAL AND FOOD/SUBSTANCE ALLERGIES

I _____(Parent/Guardian) give the staff at St. Mark's Day Care Center, Inc., permission to list and post my child's _____(child's name) who has _____(list medical and/or food/substance allergy) on the Child Medical and Food/Substance Allergies list, which is located in each classroom in a private section only viewable by Staff.

This list advises all staff of my child's Medical and/or Food/Substance Allergy ensuring my child remains safe at all times while under the supervision of St. Mark's Staff.

I have read the above request and I fully understand that my child's information will remain private and is only viewed by staff. Upon signing I agree to have my child's main listed on the Child Medical and Food/Substance Allergy list.

_____ _____

Parent's / Guardian's Signature Date

(OFFICE USE ONLY)

ST. MARK'S DAY CARE CENTER, INC.

CHILD INTAKE/CHANGE FORM

TYPE: ☐ New ☐ Change ☐ Termination

EFFECTIVE DATE:____/_____/_____

SECTION I: CHILD INFORMATION

FIRST NAME:_____LAST NAME:_____

RACE:_____DATE OF BIRTH:____/__/____ GENDER:_____

ADDRESS:_____

_____

NAME OF SIBLING(s) (if enrolled at SMDCC):_____

SECTION II: PARENT INFORMATION

FIRST NAME:_____LAST NAME:_____

FAMILY SIZE:_____ Social Security Number _____-_____-_____

HOME TEL. # CELL#: WORK TEL. #:

(_____)_____-_____ (_____)_____-_____ (___)_____-_____

SECTION III: FINANCIAL INFORMATION

INCOME:_____WEEKLY/MONTHLY FEE: _____

SDE Weekly Fee: ____ Weekly C4K's Pending Fee: ____ $10.00 Application Fee____

___ SMDCC I ___SMDCC II ___Infant __Preschool ___School Age Unit:___

Care 4 Kids Application Submission Date: __/__/__ Care 4 Kids Approval Date: ___/__/__

LUNCH ELIGIBILITY: FREE ____ REDUCED ____ OVER INCOME _____

SECTION IV: INSURANCE INFORMATION

HEALTH INSURANCE: _____ PRIVATE ____ STATE ____ NO INSURANCE

PHYSICIAN: Yes_____ No_____ Allergies: _____

SECTION IV: CHANGE INFORMATION

REASON FOR CHANGE IF APPLICABLE:_____

_____

cc: Child's Folder/Business Manager/Head Teacher/Office Manager

ST. MARK'S DAY CARE CENTER, INC.
INCOME VERIFICATION APPLICATION

Child's Name: _____ Age: _____ Birth Date: ___/___/___

Home Tel.#_____ Work Tel.#_____ Cell #_____

Home
Address:_____
Street **City - State Zip**

LIST THE NAMES OF ALL FAMILY MEMBERS	Gross Earnings from work/job for each member (Before Deductions)	CIRCLE ONE Welfare, Child Support, Alimony	**Payments from Pensions, Retirement, Social Security**	Earnings from P.T. job or other income
	Amounts/HOW OFTEN	Amounts/HOW OFTEN	Amounts/HOW OFTEN	Amounts/HOW OFTEN
	/per	/per	/per	/per
	/per	/per	/per	/per
	/per	/per	/per	/per

FOSTER CHILD: If care is for a foster child, check here ( ) Amount and how often it is received here: $ Per Month

SIGNATURE: The Adult household members must sign and date the application before it can be approved including the following: ***Legally Married Adults – Biological Parents who are not married but who reside in this household.***

Signature of Adult: _____ Social Security Number ____-____-____.

Print Name of Adult: _____Date Signed: _____

Signature of Adult: _____ Social Security Number ____-____-____.

Print Name of Adult: _____Date Signed: _____

Total Family Income: $_____ **Family Size:** _____
(Calculated from Pay Stubs)

Sponsor Eligibility Official: _____ **Date:** _____

Program: _____ **I** _____ **II** **Parent Fee:** _____ **Parent C4K's Pending Fee:** _____

SDE Eligible: ____**Yes** _____**No** **Open Slots:** _____ **Yes** _____ **No** **Rate:**_____

Parent initials for receipt of income verification copy_____

Accepting/Rejecting Infant Formula in the Child and Adult Care Food Program (CACFP)

Section 1: To be completed by the center or day care provider

Name of center/provider: St Marks Day Care Center Inc.

Infant formula served by center/provider: Infamil Infant

*Name of approved iron-fortified infant formula **

* **Note:** Infant formula offered by the center/provider must be **iron-fortified** and comply with the USDA infant formula regulations in USDA Memo CACFP 02-2018: *Feeding Infants and Meal Pattern Requirements in the Child and Adult Care Food Program; Questions and Answers.*

Section 2: To be completed by the parent/guardian

Name of infant: _____ Birth date: _____

Name of parent/guardian: _____

Check all that apply:

☐ I would like my child to receive the above named iron-fortified infant formula supplied by the center/provider.

☐ I will provide my own infant formula: _____

*Name of approved iron-fortified infant formula ***

** **Note:** Infant formula provided by the parent/guardian must be **iron-fortified** and comply with the USDA infant formula regulations indicated in USDA Memo CACFP 02-2018: *Feeding Infants and Meal Pattern Requirements in the Child and Adult Care Food Program; Questions and Answers.* Infant formulas that do not meet these requirements cannot be substituted unless an infant has a disability that restricts his/her diet, and the parent/guardian provides a medical statement signed by a recognized medical authority. Recognized medical authorities include physicians, physician assistants, doctors of osteopathy, and advanced practice registered nurses (APRNs). Medical statements are available on the Connecticut State Department of Education's (CSDE) Special Diets in CACFP Child Care Programs webpage.

☐ I will provide expressed breast milk for my child.

☐ I will breastfeed my child on site in the day care center or family day care home.

Parent/guardian signature: _____ Date: _____

For more information, visit the CSDE's Feeding Infants in CACFP Child Care Programs webpage or contact the CACFP staff in the CSDE, Bureau of Health/Nutrition, Family Services and Adult Education, 450 Columbus Boulevard, Suite 504, Hartford, CT 06103-1841.

This form is available at https://portal.ct.gov/-/media/SDE/Nutrition/CACFP/Infants/Accepting_Rejecting_Infant_Formula_CACFP.pdf.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: How to File a Complaint, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
(2) fax: (202) 690-7442; or
(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

The Connecticut State Department of Education is committed to a policy of equal opportunity/affirmative action for all qualified persons. The Connecticut Department of Education does not discriminate in any employment practice, education program, or educational activity on the basis of age, ancestry, color, criminal record (in state employment and licensing), gender identity or expression, genetic information, intellectual disability, learning disability, marital status, mental disability (past or present), national origin, physical disability (including blindness), race, religious creed, retaliation for previously opposed discrimination or coercion, sex (pregnancy or sexual harassment), sexual orientation, veteran status or workplace hazards to reproductive systems, unless there is a bona fide occupational qualification excluding persons in any of the aforementioned protected classes.

Inquiries regarding the Connecticut State Department of Education's nondiscrimination policies should be directed to: Levy Gillespie, Equal Employment Opportunity Director/Americans with Disabilities Coordinator (ADA), Connecticut State Department of Education, 450 Columbus Boulevard, Suite 505, Hartford, CT 06103, 860-807-2071, levy.gillespie@ct.gov.

Child and Adult Care Food Program (CACFP)

Income Eligibility Application for Child Care Centers and Head Start

For instructions, see *Instructions for Income Eligibility Application for Child Care Centers and Head Start.*

Part 1 — Child's information

Child's name: _____ Age: _____ Birth date (*month, day, year*): _____

Child's normal child care schedule (*Check all days that apply*):

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ■ Saturday ■ Sunday

Child's normal hours of care *(include time and circle AM or PM)*:

_____ AM/PM to _____ AM/PM and _____ AM/PM to _____ AM/PM

Normal meal services provided to child *(Check all meals/snacks that apply)*:

☐ Breakfast ■ A.M. Snack ☐ Lunch ☐ P.M. Snack ■ Supper

Part 2A — Participants categorically eligible as free for CACFP benefits

Households receiving Supplemental Nutrition Assistance Program (SNAP) (formerly known as Food Stamps) or Temporary Family Assistance (TFA) benefits, and households with foster children. Complete this part and part 3. Do **not** complete part 2B.

SNAP case number: _____ TFA case number: _____ Check if foster child: ☐

Part 2B — All other households

If you did not complete part 2A, complete this part and part 3.

Names of all household members *List everyone in the household, including the child listed in part 1 above*	**Gross income and how often it was received:** Indicate if income was received monthly, two times a month, every two weeks, or weekly by placing the **amount of income** in the appropriate frequency box. *You must place the income in the appropriate frequency box.*											
	Earnings from work (before deductions) – job 1				**Public assistance/ alimony/child support**				**Pensions/retirement/social security/all other income**			
Names	Weekly	Biweekly Every 2 weeks	2 X Month	Monthly	Weekly	Biweekly Every 2 weeks	2 X Month	Monthly	Weekly	Biweekly Every 2 weeks	2 X Month	Monthly
(Example) Jane Smith	$200					$134						
1.												
2.												
3.												
4.												
5.												
6.												
7.												
8.												

Part 3 — Contact information, signature, and social security number

*An adult household member must **sign and date** this form before it can be approved.*

I certify (promise) that all information on this form is true and that all income is reported. I understand that the center will receive federal funds based on the information I provide. I understand that CACFP officials may verify (check) the information. I understand if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable state and federal laws.

Printed name of adult: _____ Signature: _____

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

Home telephone: _____ Work telephone: _____

Home address: _____ City: _____ State: _____ Zip code: _____

CACFP Income Eligibility Application for Child Care Centers and Head Start

Part 4 — Racial and ethnic identity (optional) *You are not required to complete this part.*

Ethnicity ***(Check one):***

- ☐ Hispanic/ Latino
- ☐ Not Hispanic/Latino

Race ***(Check one or more):***

- ☐ Asian
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or other Pacific Islander

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: How to File a Complaint, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
(2) fax: (202) 690-7442; or
(3) email: program.intake@usda.gov.

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CSDE
CONNECTICUT STATE DEPARTMENT OF EDUCATION

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For Sponsor Use Only – Do Not Write Below This Line

Annual income conversion: Weekly X 52 • Every 2 weeks X 26 • Twice a month X 24 • Monthly X 12

Total family income: $ _____ Family size: _____ **OR** ☐ SNAP/TFA household ☐ Foster child

☐ Eligible Free ☐ Eligible Reduced ☐ Over Income

Sponsor eligibility official: _____ Date: _____

Signature

Child and Adult Care Food Program (CACFP) Child Enrollment Form for Child Care Centers

Our child care center participates in the U.S. Department of Agriculture (USDA) CACFP. This program helps us provide nutritious meals and snacks to children enrolled in our center. For information on the CACFP meal pattern requirements, review the CACFP Meal Patterns for Children and the CACFP Infant Meal Patterns at https://portal.ct.gov/SDE/Nutrition/Meal-Patterns-CACFP-Child-Care-Programs.

Section 1 – Waiver of CACFP participation

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

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

Section 2 – CACFP enrollment

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

Child care center's name: St. Marks Day Care Center Inc.

Child's name: _____ Birth date: _____
Last name *First name* *Month, day, year*

☐ Male ☐ Female First day of attendance: _____

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

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

For infants only

Infant formula: The center offered to serve: _____

*Name of approved iron-fortified infant formula **

Check all that apply:

- ☐ I would like my child to receive the above named iron-fortified infant formula supplied by the center.
- ☐ I will provide my own infant formula: _____

  *Name of approved iron-fortified infant formula **
- ☐ I will provide expressed breast milk for my child.
- ☐ I will breastfeed my child on site in the center.

* **Note:** Infant formula provided by the parent/guardian must be **iron-fortified** and comply with the USDA's infant formula regulations indicated in USDA Memo CACFP 02-2018: *Feeding Infants and Meal Pattern Requirements in the Child and Adult Care Food Program; Questions and Answers.* Infant formulas that do not meet these requirements cannot be substituted unless an infant has a disability that restricts his/her diet, and the parent/guardian provides a medical statement signed by a recognized medical authority. Recognized medical authorities include physicians, physician assistants, doctors of osteopathy, and advanced practice registered nurses (APRNs). Medical statements are available on the Connecticut State Department of Education's (CSDE) Special Diets in CACFP Child Care Programs webpage.

Section 3 – Contact information and signatures

Parent/guardian name: _____

Address: _____ City: _____ State: _____ Zip: _____

Work phone: (_____) _____ Home phone: (_____) _____

Parent signature: _____ Date: _____

Sponsor representative's signature: _____ Date: _____

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: How to File a Complaint, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
(2) fax: (202) 690-7442; or
(3) email: program.intake@usda.gov.

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CSDE

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Child and Adult Care Food Program (CACFP)

Instructions for Income Eligibility Application for Child Care Centers and Head Start

Complete the Income Eligibility Application using the instructions below. Please complete one application for each enrolled child. Sign the application and return it to the child care center. If you have any questions or need help filling out the application, contact Tenisha Holeyfield at (203) 335-3828 Ext 113.

Part 1 — Child's information

All households must complete this part.

1. Print the name of the child enrolled in the center, and indicate the child's age and birth date (month, day and year).
2. **Child's normal child care schedule:** Check (☑) all days of the week the child will normally attend the center.
3. **Child's normal hours of care:** Indicate the times of day the child will normally attend the center, and circle AM (morning) or PM (afternoon).
4. **Normal meal services provided to child:** Check (☑) the meals the child will normally be served while in care at the center.

Part 2A — Participants who are categorically eligible as free for CACFP benefits

Complete this part only if your household receives Supplemental Nutrition Assistance Program (SNAP) (formerly known as Food Stamps) or Temporary Family Assistance (TFA) benefits, or your household includes a foster child. ***Do not complete part 2B. Sign and date the application in part 3.***

1. List the current SNAP case number or the TFA case number for the child.
2. Check (☑) the box if the child is a foster child who has been placed by a state or local agency.

Part 2B — All other households

Complete this part if you did not complete part 2B.

1. Write the names of everyone in your household including parents, grandparents, all children, other relatives and unrelated people who live in your household.
2. Write the **amount of income** (the amount before taxes or anything else is taken out) received **last** month for each household member and **where it came from**, such as earnings, welfare, pensions and other income. The table below provides examples of types of income to report. If any amount **last month** was more or less than usual, write that person's usual income.
3. An adult household member must sign and date this application in part 3, and provide the last four digits of their social security number.

Income to report		
Earnings from work	**Public assistance/alimony/ child support**	**Pensions/retirement/ all other income**
• Salary, wages, cash bonuses • Net income from self-employment (farm or business) • Strike benefits **If you are in the U.S. Military:** • Basic pay and cash bonuses (*do NOT include combat pay, FSSA, or privatized housing allowances*) • Allowances for off-base housing, food, and clothing	• Unemployment benefits • Worker's compensation • Supplemental Security Income (SSI) • Cash assistance from State or local government • Alimony payments • Child support payments • Veteran's benefits	• Social Security (including railroad retirement and black lung benefits) • Private Pensions or disability • Income from trusts or estates • Annuities • Investment income • Earned interest • Rental income • *Regular* cash payments from outside household

Part 3 — Contact information, signature, and social security number

All households must complete this part.

1. An adult household member must **sign and date** this form.
2. If you complete part 2A and list a SNAP or TFA number, or the child is a foster child, you do **not** need to provide the last four digits of the adult household member's social security number.
3. If you complete part 2B, the adult household member who signs the application must include the **last four digits** of their social security number. If this person does not have a social security number, check (☑) the box next to the statement, "I do not have a SSN."

Part 4 — Racial/ethnic identity (optional)

Complete this part if you wish.

The CACFP facility is required to ask for information about your children's race and ethnicity. This information is important and helps ensure the CACFP facility is fully serving their community. Responding to this section is **optional** and does not affect your children's eligibility for CACFP meals.

1. Check one ethnicity, either "Hispanic Latino" or "Not Hispanic/Latino."
2. Check one or more races (Asian, White, Black or African American, American Indian or Alaska Native, and Native Hawaiian or other Pacific Islander).

CSDE
CONNECTICUT STATE DEPARTMENT OF EDUCATION

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(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
(2) fax: (202) 690-7442; or
(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Sample Parent Letter for Child Day Care Centers

Dear Parent or Guardian:

The St. Marks Day Care Center/Head Start Program is planning to seek assistance for nutritious meals served under the Child and Adult Care Food Program (CACFP). The CACFP is funded by the U.S. Department of Agriculture (USDA) and administered by the Connecticut State Department of Education.

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

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

Participants categorically eligible as free for CACFP benefits: Households receiving Supplemental Nutrition Assistance Program (SNAP) (formerly known as Food Stamps) or Temporary Family Assistance (TFA) benefits, and households with foster children are eligible for free CACFP meals.

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

All other households: If your household income is at or below the level shown in the chart on page 2, "Gross Income Guidelines for Reduced-price Meals," you must provide the following information for your application to be processed.

- **Household members:** List the names of everyone who lives in your household. Include parents, grandparents, **all** children, other relatives, and unrelated people who live in your household.

- **Social Security number:** List the last four digits of the social security number of the adult household member who signs the application. If the adult does not have a social security number, check (☑) the box next to the statement, "I do not have a SSN."
- **Current income:** List the amount of income each person earned **last** month (*before* deductions for taxes, social security, etc.), and where it is from, such as wages, retirement, or welfare. If any household member's income last month was higher or lower than usual, list that person's usual average monthly income.

Signature and date: An adult household member must **sign and date** the application.

Reporting changes: In accordance with the Child Nutrition and WIC Reauthorization Act of 2004, households are no longer required to report changes in circumstances, e.g., increase in income, decrease in household size, or when the household is no longer certified eligible for SNAP or TFA benefits. Once properly approved for free or reduced-price benefits, a household will remain eligible for those benefits for a period not to exceed 12 months.

Reapplication: If you are not eligible now but have a decrease in household income, an increase in household size, or become unemployed, fill out an application at that time. Participants having family members who become unemployed are eligible for free or reduced-price meals during the period of unemployment, provided that the loss of income causes the family income during the period of unemployment to be within the eligibility standards for those meals.

Gross Income Guidelines for Reduced-Price Meals
Effective from July 1, 2020, through June 30, 2021

Number in family	Annual (yearly)	Monthly	Twice per month	Every two weeks (biweekly)	Weekly
1	23,606	1,968	984	908	454
2	31,894	2,658	1,329	1,227	614
3	40,182	3,349	1,675	1,546	773
4	48,470	4,040	2,020	1,865	933
5	56,758	4,730	2,365	2,183	1,092
6	65,046	5,421	2,711	2,502	1,251
7	73,334	6,112	3,056	2,821	1,411
8	81,622	6,802	3,401	3,140	1,570
Each additional family member	+ 8,288	+ 691	+ 346	+ 319	+ 160

Connecticut WIC
NUTRITION IS JUST the BEGINNING

CONNECTICUT WIC PROGRAM

INCOME ELIGIBILITY FOR THE WIC PROGRAM *

FOR PERIOD OF JULY 1, 2020 – JUNE 30, 2021

Family Size	Annual	Monthly	Twice-Monthly	Bi-Weekly	Weekly
1	$ 23,606	$ 1,968	$ 984	$ 908	$ 454
2	31,894	2,658	1,329	1,227	614
3	40,182	3,349	1,675	1,546	773
4	48,470	4,040	2,020	1,865	933
5	56,758	4,730	2,365	2,183	1,092
6	65,046	5,421	2,711	2,502	1,251
7	73,334	6,112	3,056	2,821	1,411
8	81,622	6,802	3,401	3,140	1,570
For each additional family member, add:	+ 8,288	+ 691	+ 346	+ 319	+ 160

* Based on HHS Federal Poverty Guidelines.

For example, a family of four can make up to $48,470 gross income (before taxes) a year to be income eligible.

This institution is an equal opportunity provider.
Esta institución es un proveedor que ofrece igualdad de oportunidades.

5/2020

STATE OF CONNECTICUT-DEPARTMENTOF PUBLIC HEALTH-SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS AND CHILDREN-WIC PROGRAM-LOCAL AGENCY LISTING

WIC Local Agency	Address	City, Zip	Phone Number/FAX	Email
ACCESS AGENCY (2): **Windham/Willimantic** **Day Kimball Hospital**	1315 Main Street Suite 2	**Willimantic** 06226	(860) 450-7405 Fax 450-7477	WIC@ACCESSAGENCY.ORG
	255 Pomfret Street-**DELIVERIES** 320 Pomfret Street-**MAIL**	**Putnam** 06260	(860) 928-3660 Fax 963-6325	DKHWIC@GMAIL.COM
OPTIMUS HEALTH CARE Inc. (4): **Bridgeport** **Southwest Community Health Center**	1450 Barnum Avenue Suite 205	**Bridgeport** 06610	(203) 333-9200 Fax 683-3616	WICBRIDGEPORT@OPTHC.ORG
	1020 Fairfield Avenue	**Bridgeport** 06605	(203) 332-4600 Fax 332-4699	WIC@SWCHC.ORG
Stamford	805 Atlantic Street, 2nd Fl. -**DELIVERIES** 1450 Barnum Avenue-**Mail**	**Stamford** 06902	(203) 977-4385 Fax 977-5966	WICSTAMFORD@OPTHC.ORG
Norwalk Health Department	137 East Avenue	**Norwalk** 06851	(203) 854-7885 Fax 854-7926	NHDWIC@NORWALKCT.ORG
BRISTOL HOSPITAL(2): **Bristol**	11 Bellevue Ave	**Bristol** 06010	(860) 585-3280 Fax 585-3977	BRISTOLWIC@BRISTOLHOSPITAL.ORG
New Britain	450 Main Street	**New Britain** 06051	(860) 225-8695 Fax 225-8698	NBWIC@BRISTOLHOSPITAL.ORG
CT Institute for Families (CIFC) **Danbury**	80 Main Street	**Danbury** 06810	(203) 456-1410 Fax 917-3567	WIC1@ct-institute.org
EAST HARTFORD	50 Chapman Place 740 Main Street-**MAIL**	**East Hartford** 06108	(860) 528-1458 #1 Fax 282-4861	WIC@EASTHARTFORDCT.GOV
HARTFORD (2): **Burgdorf Health Center**	131 Coventry Street	**Hartford** 06112	(860) 757-4780 Fax 722-8062	HARTFORDWIC@HARTFORD.GOV
Main Street	175 Main Street	**Hartford** 06106	(860) 757-4860 Fax 722-8044	HARTFORDWIC@HARTFORD.GOV
MERIDEN (2):	165 Miller Street	**Meriden** 06450	(203) 630-4245 Fax 630-4249	MERIDENWIC@MERIDENCT.GOV
Middletown	8 Crescent Street	**Middletown** 06457	(860) 358-4070 Fax 358-4075	WIC@MIDHOSP.ORG
YALE NEW HAVEN HOSPITAL (4): **St. Raphael Campus**	1401 Chapel Street 1450 Chapel Street-**MAIL**	**New Haven** 06511	(203) 789-3563 Fax 867-5208	WICSRC@YNHH.ORG
Fair Haven Health Center	350 Grand Avenue	**New Haven** 06513	(203) 773-5007 Fax 401-2044	WIC@FHCHC.ORG

Rev. 12/2020

ST. MARK'S DAY CARE CENTER, INC.

PERMISSION SLIP TO WALK CHILDREN TO NEIGHBORHOOD OUTINGS

I,_____(Parent/Guardian) give the staff at St. Mark's Day Care Center, Inc., permission to walk my child _____, to attend his/her school classes and return him/her back to St. Mark's Day Care Center, Inc. at 368-70 Newfield Avenue, Bridgeport, Connecticut 06607.

I also give the staff at St. Mark's Day Care Center, Inc. permission to escort my child to and from St. Mark's Day Care Center, Inc. to visit the: Library, Local Businesses, Community Facilities and other Neighborhood Outings, (i.e. Nature Walks).

Any other fieldtrips which require transportation will require a special permission slip to be signed by a parent prior to the fieldtrip.

_____ _____

Parent/Guardian Signature Date

PERMISSION SLIP TO ALLOW MEDIA AND PHOTOGRAPHS TAKEN OF CHILDREN FOR CENTER, WEBSITE AND/OR COMMUNITY EVENTS

I,_____(Parent/Guardian) give the staff at St. Mark's Day Care Center, Inc., permission to take photos and videos of my child _____, for Center Website and/or Community Event purposes only.

_____ _____

Parent/Guardian Signature Date

Dr. *Sheila M. Kearney, Interim Executive Director*
St. Mark's Day Care Center, Inc.

Program Policy: Care4Kids Process & St. Mark's Day Care Center Policy

All child-care parents newly enrolled and participating in the DSS State of Connecticut Contracted Slots must complete an application for the Connecticut Child Care Assistance Program (Care4Kids). The completion of this application determines the family's eligibility for the additional child-care subsidy assistance. In addition, all child-care parents currently receiving Care4Kids must comply with the Care4Kids Re-Determination process as outlined below.

Parents must comply with the Care4Kids process by meeting their requirements (i.e., furnishing requested documents, including the child support notification, and meeting the required submission deadline). Failure to follow through with the Care4Kids process will result in a denial letter indicating ineligibility for the Care4Kids subsidy funds, therefore forfeiting the child care assistance.

Failure to provide the required documents as part of the Care4Kids process will also result in the termination of the SDE funded child-care services at St. Mark's Day-Care Center, Inc. based upon written notification from Care4Kids.

The Care4Kids subsidy funds are in place to support families who need child-care assistance and to child-care providers such as St. Mark's to cover the operating expenses needed in providing quality care.

Parent Signature:_____ Date:_____

368-70 Newfield Avenue – Bridgeport, Connecticut 06607 – Phone (203) 335-3828 – Fax: (203) 335-4344

ST. MARK'S DAY CARE CENTER, INC.

Connecticut State Department of Education

Sliding Fee Scale

*State Department of Education (SDE) Contracted Slots

The State Department of Education has contracted with St. Mark's Day Care Center, Inc. to provide subsidized units of child care for infants, pre-school and school-age children.

Families identified as eligible for and assigned a SDE-supported child care slot must pay the determined weekly rate fee each week.

The weekly rate is determined based on family size and income. The weekly rate once determined will be reassessed on a bi-annual (6 month) basis. Each family is immediately required to notify the program staff regarding a significant decrease, or $50.00 increase, in income.

In the case of a vacation, not to exceed a period of two weeks per year, the family is required to pay the determined weekly rate. The child care slot cannot be saved during extended absences unless the family agrees to pay the required weekly rate.

In the case of an extended illness, the family is required to pay the determined rate, unless a note from an M.D. is submitted stating the nature and duration of illness.

When there are significant absences, and sporadic attendance, without explanation, the program may determine assigning the subsidized slot to another family.

_____ _____

Parent Signature Date

St. Mark's Day Care Center, Inc.

Emergency and Pick-Up Listing and Reauthorization

List 4 relatives/friends authorized to pick up your child and to be contacted in case of an emergency, if parent(s) cannot be reached. Telephone numbers are mandatory and will be checked throughout the year. An adult 18 years or older will be allowed to pick up a child.

AN ID MUST BE PROVIDED IN ORDER TO PICK UP A CHILD

PLEASE UPDATE THE FOLLOWING INFORMATION

MOTHER:_____ CHILD:_____DOB:____/_____/_____

ADDRESS:_____CITY/ZIP CODE:_____
CELL PHONE: (_____) _____-_____CHILD'S UNIT: _____
HOME PHONE: (_____)_____-_____WORK PHONE: (_____)_____-_____

FATHER:_____

ADDRESS:_____CITY/ZIP CODE:_____
CELL PHONE: (_____) _____-_____CHILD'S UNIT: _____
HOME PHONE: (_____)_____-_____WORK PHONE: (_____)_____-_____

AUTHORIZED PICK-UP PERSON(S):

1. NAME_____ ADDRESS: _____

   RELATIONSHIP_____ (H)_____ (C)_____ (W)_____

2. NAME_____ ADDRESS: _____

   RELATIONSHIP_____ (H)_____ (C)_____ (W)_____

3. NAME_____ ADDRESS: _____

   RELATIONSHIP_____ (H)_____ (C)_____ (W)_____

4. NAME_____ ADDRESS: _____

   RELATIONSHIP_____ (H)_____ (C)_____ (W)_____

Physician_____ Telephone (_____) _____-_____

Hospital Preference_____ Health Insurance_____

I understand that it is my responsibility to inform St. Mark's Day Care Center, Inc. whenever there is a change in the information recorded on this form. This includes a change in telephone numbers, and Pick-Up Listing. Parental cooperation is essential for my child's security.

I submit that the above information is correct.

_____ _____

Signature of Parent/Guardian Date

ST. MARK'S DAY CARE CENTER, INC.
PARENT FEE AGREEMENT

_____ YOUR CHILD _____
(Parent's Name) (Child's Name)

Your child will be assigned to the following unit, the private daycare fees will be at a rate of:

* Infant/Toddler ($250 wk)
* Preschool ($170wk)
* School Age ($150wk - FT Summer & Vacation wks)
* School Age - Sep-Jun ($75wk – PT Before/After & No School/½ days)

Contract (see below)

Effective Date _____ /PLEASE COMPLETE ATTENDING HOURS:

* Infant hours:_____am/_____pm
* Pre-School hours:_____am/_____pm
* School Age hours:_____am/_____pm
* Vacation & Summer hours:_____am/_____pm

(*) The part-time School Age hourly rate is $4.00. The weekly rate will be determined by the parent's indication of hours needed at the $4.00 rate, if utilized or not. Monthly accumulated hours that exceed the weekly number of hours agreed upon will be charged to the account at the $4.00 per hour rate.

*Daycare fees are to be paid at the start of the week -- every **Monday**. Missing weekly child care payments will be cause for termination of your child care services.*

If you have applied for a Care4Kids subsidy, the full determined fees are to be paid on Mondays of each week pending the approval of your Care4Kids application. Once the amount to be paid by Care4Kids has been determined, your daycare service account will be adjusted accordingly. You are responsible for any/all unpaid account balances that Care4Kids does not cover from your child's care start date to the Care4Kids determination date. You will then be notified to arrange for a re-adjustment in your payment activity. Any payment you have made that is covered by Care4Kids will be refunded after the first Care4Kids payment is received. If you are receiving a SDE subsidy, the parent payments are based on family size and income**, and you must pay weekly on ***Mondays***. If you receive Care4Kids benefits, the parent fee will be a Care4Kids Family Fee determination until such time that the Care4Kids benefits change or cease. It will then revert back to the SDE income fee scale determination until Care4Kids is approved.

(**) Total family income is based on Legally Married Adults and Biological Parents who are not married however reside in the same household. False or missing information will be cause for termination of our child care services. All changes in income increase or decrease must be reported within 15 days with new income being submitted. The re-determination of fees may be processed every 6 months (Jun-Dec) Accounts not having completed the form and information by the requested deadline will be ***charged a non-refundable late fee of $25.00 per week*** until the parent fee agreement is complete.

DETERMINED FEE:

Private Family Fee: $_____per week Private/C4K's Family Fee: $_____per week or $_____per month
SDE Contracted Family Fee: $_____per week SDE/C4K's Family Fee: $_____per week or $_____ per month

C4K's Certificate starts:_____ and ends on:_____

_____ _____
(Agent Signature) (Parent Signature)

_____ _____
(Date) (Date)

Parent Initials for receipt of payment agreement: _____

ST. MARK'S DAY CARE CENTER, INC.
PARENTS STATEMENT OF AGREEMENT

1. I agree to provide proof of all health screening immunization records for my child. I understand that it is my responsibility to assure that there is a current physical (not more than one year old on file).
2. I agree to *honor the arrival and pick-up times and to sign my child in and out daily* as I agreed to when I enrolled my child.
3. If I am not able to pick up my child at the agreed upon time, I will call to inform the Center of my delay and/or make arrangements to have someone pick up my child. I must inform the Center of these arrangements.
4. The ***late fee charge is $15.00 for every 15 minutes I am late (past 5:30pm-NO EXCEPTIONS).***
5. I agree to provide 2 changes of clothing to be kept at the Center for my child in the event of an accident.
6. I agree to keep my child home from the Center if he/she has a cold or has a temperature of at least 100 degrees F. If my child is brought to the Center in this condition, I understand that I will be contacted to have him/her picked up and taken home immediately. (within 1 hour).
7. If my child develops an illness and/or contagious disease that requires my child to be absent from the Center for a period of time, I agree to notify the Center of this condition and to submit a Doctor's note in order for my child to return to the program.
8. *Child Care Fees Policy*: St. Mark's Day Care Center, Inc.'s childcare payment policy is indicated in the enrollment application. ***Childcare service fees are due in full on the Monday of each week. If a Care4Kids (C4K) application is in process, the childcare fee is still due and must be paid on the Monday of each week. If your C4K application is determined eligible, any overpayment made by the parent prior to the actual C4K approval, will be returned to you when C4K Benefits have been approved based on their designated date of acceptance and the first C4K reimbursement payment received in our office.***

   If an outstanding balance is more than one week (1wk) and up to two weeks (2wks) overdue, the child will not be accepted into the Center on the Monday morning of the 3rd week. It is the parent's responsibility to check the status on an account to keep that account current. This policy is being restated to ensure that fees are paid in a timely manner. Due to the increased number of returned unpaid checks indicating insufficient funds, a service charge of $35.00 will be assessed. If a return check is received, future payments must be paid in cash or by money order. SMDCC is dependent upon the childcare service fees generated to support quality in service and programming.

Child's Name_____

Parent's Name_____ Date:_____

Our Mission Statement

An early childhood program designed to meet the special needs of Infants, Preschool and School Age children who require a full day care child experience while parents work. We provide a warm, stimulating learning atmosphere in a nurturing setting where each child can interact at their own pace. This means we will respect and encourage each child's right to personal choice in every aspect of their day. We will guide and develop their successful socialization with other children and adults, and provide stimulating and challenging learning opportunities. It is our goal to encourage tolerance and understanding of each other within the classroom, the Center, and the community.

368-70 Newfield Avenue • Bridgeport, CT 06607 • Phone: (203) 335-3828 • Fax: (203) 335-4344