EARLY LEARNING PROGRAM
20 CHURCH STREET, NH 06510
Early Learning Center (gatewayct.edu)

Early Learning Center Program Application			
Childs name:	Date of Birth:	Circle one: Male Female	
Street Address:	City:	Zip Code:	
Telephone:	Home Language:		
Does your child have any preschool or daycare experience? Yes ☐ No ☐	If yes, where?		
Has your child received Birth to 3 services? Yes ☐ No ☐ Are you seeking support in a referral or evaluation for your child? Yes ☐ No ☐	If Applicable, have you followed up with your child's pediatrician about your uncertainties?		
Parent Name:	Email:		
Parent Address (if different from above)			
Company Name and Occupation:		Business Phone:	
Work Address:		Home Phone:	
		Work Hours:	
Student FT/PT	College:	Cell Phone:	
Parent Name:	Email:		
Parent Address (if different from above)			
Company Name and Occupation:		Business Phone:	
Work Address:		Home Phone:	
		Work/School Hours:	
Student PT/FT	College:	Cell Phone:	

Other Children in the Family				
List Oldest First	At Home: Yes or No	School and Grade Level	DOB	Sex

Other Adults in the Home	Age	Relation to Child

Total Number of Members in Household:

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General Information on Allergies				
Does your child have any known or suspected allergies? Yes ☐ No ☐, If Yes please list what they are allergic to: _____, _____, _____ Does your child have an Epi Pen or Epi Pen Junior or medication for allergies? Yes ☐ No ☐ Does your child have any food restrictions due to religion or culture? Yes ☐ No ☐, If yes, please list: _____, _____, _____				
Is your child completely toilet trained? Yes ☐ No☐	How did you hear about the Early Learning Center?			
The Early Learning Program offers partially funded slots through their School Readiness funding for New Haven Residents, are you interested in a partially funded slot? Yes ☐ No ☐ Are you currently a Connecticut State Community College student and are receiving PELL Grant? Yes ☐ No ☐				
Name of Health Insurance, please circle appropriate box.	State	Private	Husky	Uninsured

Parent or caretaker signature: _____ Date: _____

Childs name: _____ Date of Birth: _____

Classroom of choice: _____ Weekly Fee: _____

Pick-up times:	Allergy and Medication Forms
Service Agreement	Food Form
School Readiness Income Verification	C4K
Student Registration	Parent Handbook
Child Information/Language Survey	Permission Form
Medical Form and Date of Exam	3 Emergency Numbers

ALL INFORMATION OBTAINED ON THIS FORM WILL BE HELD STRICTLY CONFIDENTIAL AND FOR INTERNAL PROGRAM NEEDS ONLY.

No child will attend without this list being complete prior to the start of school.
You may use the same 3 names for each list; however, you must fill out the complete list:

Child's pediatrician or clinic: _____

Address: _____ Telephone: _____

Hospital of your choice in case of emergency: _____

*Persons to be notified in case of any emergency if we cannot reach parents/guardian:

Name: _____ Cell or Home Tel. _____

Relationship to child: _____ Email: _____

Name: _____ Cell or Home Tel. _____

Relationship to child: _____ Email: _____

Name: _____ Cell or Home Tel. _____

Relationship to child: _____ Email: _____

*Please list the names of anyone authorized to pick up your child:

Name: _____ Cell or Home Tel. _____

Relationship to child: _____ Email: _____

Name: _____ Cell or Home Tel. _____

Relationship to child: _____ Email: _____

Name: _____ Cell or Home Tel. _____

Relationship to child: _____ Email: _____

All about Me!

Please take a few minutes to share information about your child's needs, strengths, and abilities.

1. What types of things does your child enjoy learning? _____

_____

_____

2. What things are the most difficult for your child to learn? _____

_____

_____

3. What is your child's sleep time routine? _____

_____

_____

4. How much screen time does your child have? What devices do they use examples tablet, Nintendo Switch, Play Station, TV? _____

_____

_____

5. What strategies do you use at home to praise your child? _____

_____

_____

6. What strategies do you use at home to redirect your child's behavior? _____

All about Me!

7. What kind of support or help, if any, does your child need during routines such as eating, dressing, toileting, napping, etc.? _____

9. Please share any traditions, or cultural beliefs that your family embraces? _____

10. What other information would you like to share about your child? _____

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Child's Name_____ Date of Birth: _____

HOME LANGUAGE AND CULTURAL SURVEY

List the **languages your child** is exposed **to (relatives, child care providers, family members etc.)**

_____

What is **your child's primary** language? _____

What **languages are used** to communicate **with your child?** _____

Language	Only	Sometimes	Mostly	Equally	By whom

Are you **comfortable speaking** English? Yes ☐ No☐ **Do you understand English?** Yes☐ No ☐

Do you **read English?** Yes ☐ No ☐ **Will you require an Interpreter?** Yes ☐ No ☐

Do you **have someone available to translate?** Yes☐ No ☐

Tell us **about foods your family's traditions and values?** _____

_____

_____

Tell us **about things you like to do together as a family.** _____

_____

_____

Tell us **what you do to celebrate your favorite holiday, or if you do not celebrate holidays.**

_____

_____

Do you **travel to visit family** or friends? _____

_____

_____

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EARLY LEARNING CENTER SERVICES AGREEMENT

_____To pay the above referenced weekly tuition *regardless of school closing and/or illness of my child*, unless notice of termination from the program has been duly received at the ELC (Early Learning Center).

_____To pay the non-refundable security deposit (one week's tuition) prior to my child's enrollment and understand that this amount will be credited to my child's last week in the day care center. If your child does not come to school in the fall, she/he will lose their slot and deposit.

_____To make all tuition payments on Friday *PRIOR* to the week of service. I understand that, if payment is not received, weekly services will be terminated.

_____I have reviewed the family fee calculations and agree to the family fee of $_____, for my child _____, effective _____.

_____To arrive at the ELC by 9:15 a.m.

_____To pick up my child from the ELC promptly by the closing time at 5:30 p.m. If my child is not picked up at closing, I will receive a Late Pick-up Fee Notice with the amount I am to pay. I agree to pay the Late Pick-up Fee to the payment office by Friday of that week.

_____To provide the director of the ELC with three emergency telephone numbers to be kept on file if the College cannot reach me directly.

_____To notify the school if my child will be absent.

_____To notify the Director of the ELC, in writing, at least two weeks in advance of my child's termination from the program.

_____To notify the Director of the ELC, in writing, at least two weeks in advance if my child is not attending during the college semester break.

_____That the ELC reserves the right to withdraw a child from the program at any time, with sufficient notification to the parent/guardian. This may be done if, in the opinion of the Center's professional staff and the College administration, it is felt to be in the best interest of the child or the Center.

CONTINUED

_____The ELC has a policy of zero tolerance. This includes any acts and/or threats of violence, or intimidation by and to employees, property, or premises of the ELC. Furthermore, verbal abuse or disrespect to ELC staff violates the NAEYC code of ethics and is unacceptable. Any frightening behavior or language in the presence of children will result in immediate and necessary action.

EARLY LEARNING CENTER SERVICES AGREEMENT

_____Each family will maintain a complete set of clean, dry clothes in the child's cubby. If clothes are not available, you will be called to either collect your child or bring in a set of clothes.

_____That my child may participate in all health activities including the following screenings and assessments: vision, dental, hearing, growth, speech, and development screening. Please notify your child's teacher if you would like to attend his/her screenings.

_____That the social services consultant will also make general observations of all children.

_____I agree that my child's file will be available to the director, the teachers, secretary, parent coordinator, and consultants that audit the program.

_____To attend two yearly ELC parent conferences with my child's teacher.

_____That my child may accompany his/her class on all scheduled walking field trips. I understand that I will be notified of any trip requiring the use of a school bus, and that those trips will have a separate permission slip to be signed prior to the day of the trip.

_____In addition, both parties agree to abide by all the provisions contained in the Gateway Community College ELC Parent Handbook, which is herein incorporated by reference.

Parent or caretaker signature: _____ Date: _____

Program Director signature: _____ Date: _____

ELC Representative Signature: _____ Date: _____

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20 CHURCH STREET, NH 06510
Early Learning Center (gatewayct.edu)

Permission Form

Child's Name_____ Date of Birth: _____

PERMISSION FOR FIELD TRIPS

I give my permission for my child to go on all field trips for as long as she/he is enrolled in the Early Learning Center. If transportation is taken from the center, a separate form will be signed.

_____ _____
Parent/Guardian Date

PERMISSION TO SHARE INFORMATION

Information concerning my child may be shared with the staff and consultants of the Early Learning Center.

_____ _____
Parent/Guardian Date

PERMISSION FOR VIDEOTAPING, FILMING, OR PHOTOGRAPHING AND STATE OF RELEASE

I hereby give permission for the staff of the Early Learning Center or its designees, to videotape or photograph my child. The photographs or films may be used for training or advertisement of the Early Learning Center program. Videotapes, films, or photographs of my child by the Early Learning Center staff or its designees are the property of Gateway Community College. I hereby waive the right to renunciation for use of the above at any time. The college may show or exhibit the videotapes, films, or photographs at any time without my prior notification.

_____ _____
Parent/Guardian Date

MEDICAL RELEASE

I hereby give permission to the Early Learning Center First Aid Certified staff or Medical Response personal such as EMT, police, nurse, or doctor to administer emergency First Aid to my child and to have my child transported by emergency vehicle to Yale-New Haven, St. Raphael's, or another emergency facility and treated. Any expense incurred through transporting and/or treating the child is the responsibility of the parent.

_____ _____
Parent/Guardian Date

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FAMILY AVAILABILITY FORM AND HANDBOOK AGREEMENT

Welcome to the ELC. We are a center that is family focused. As such, we have many enjoyable family programs that enrich your child's preschool experience, as well as educational programming for parents and caregivers. To serve our families, we ask that you take time to fill out our Family Availability Form. This form will give the Family Coordinator an idea of when to schedule FAC (Faculty Advisory Committee) meetings and family programs.

In addition, please sign below agreeing that you have received, read, and understand the Family Handbook Discipline Policies and Procedures of the Early Learning Program

Parent/ Caretaker Name: _____ Phone Number: _____

Child's Name: _____ Classroom: _____

Please check the best days and list the times that are best for you.

Monday _____am _____ pm by Phone or in person? Please circle one.
Tuesday _____am _____ pm by Phone or in person? Please circle one.
Wednesday _____am _____ pm by Phone or in person? Please circle one.
Thursday _____am _____ pm by Phone or in person? Please circle one.
Friday _____am _____ pm by Phone or in person? Please circle one.

I have read the Family Handbook and agree with the rules and regulations outlined in this manual. I have reviewed the Discipline Measures, Grievance and Conflict Resolution Policies with the staff.

Parent Signature _____ Date _____

IF YOU HAVE QUESTIONS ABOUT THIS MATERIAL, PLEASE ASK THE DIRECTOR BEFORE SIGNING THIS FORM. PLEASE COMPLETE THIS FORM AND RETURN IT TO THE PARENT COORDINATOR IN THE FRONT OFFICE.

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NEW HAVEN, CT 06510
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BANNER ID- Enrollment Form

A Connecticut Community College ID Number is required for your child to be enrolled in the Early Learning Center. Please complete the form and its entity and return it to Mary Palermo, secretary or Jisel Cordero, Director in the front office.

NOTE: This may NOT be faxed

Childs name: _____ Date of Birth: _____

Parents name: _____ Date of Birth: _____

Parent address: _____ Town: _____

State: _____ Zip code: _____

Parent email: _____ Parent phone number: _____

☐ US Citizen ☐ Permanent Resident ☐ Other: _____

NOTE: Being a US Citizen is not a requirement to enroll in our program, this information is solely used to establish a Banner ID.

Connecticut Community College ID Number: _____

Parent Social Security Number: _____

Family Fee $ _____ Care4kids recipient: YES ☐ NO ☐ Pending Application ☐

Early learning center at CT State Community College
20 Church St
New Haven, CT 06510
Office 203-285-2132
Fax 203-285-2290

Parent/Director Authorization to Enroll Child Under 3 Into Preschool Program

I give my permission for my child, _____, who is at least thirty two months old but not yet three years old, to transition into the preschool classroom on the date of_____.

I understand that the policies and procedures that are applied to children that are three years old will be applied to this child, including, but not limited to, the ratio of staff to children and group size.

Child Care Centers Ratio

A childcare center provides care to more than 12 children, with a child to caregiver ratio of:

- 10:1 for children ages three and older and
- 4:1 for children under age three (CGS § 19a-77(a)(1) and Conn. Agencies Regs 19a-79-10(c)).

Please sign and date:

Parent Signature: _____Date: _____

Director/Representative Signature: _____ Date: _____

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 I) which will be helpful to the health care provider when he or she completes the health evaluation (Part II). 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/Alaskan Native ☐ Hispanic/Latino ☐ Black, not of Hispanic origin ☐ Asian/Pacific Islander ☐ White, not of Hispanic origin ☐ Other	
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 I — 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 II — Medical Evaluation

ED 191 REV. 3/2015

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

Child's Name: _____ Birth Date: _____ REV. 3/2015

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	
Influenza						
Tdap/Td						

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 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[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]
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	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]	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 on or 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