New Client Registration Fee $5
Previous Client Registration Fee $0:
Name of current/former child enrolled:
_____

Early Learning Childcare Request Form

New Child's/Family Information

Referred by: ☐ Friend/Family ☐ Staff ☐ Agency ☐ Other

Child's Name: _____ Date of Birth: _____ Boy ☐ Girl ☐

Primary Adult's Name: _____ Date of Birth: _____

☐ Parent ☐ Guardian ☐ Foster ☐ Other _____

Street Address: _____ City/zip code: _____

Email Address: _____

Cell Phone #: _____ Provider: _____ Phone (2) #: _____ ☐Work ☐Home

Spouse/Partner (only provide if person lives with you): _____ Date of Birth: _____

Email Address: _____

Cell Phone #: _____ Provider: _____ Phone (2) #: _____ ☐Work ☐Home

Primary Language spoken at home: _____ Secondary language: _____

Does your child receive any special services or require special accommodations? ☐Yes ☐No If yes, please describe:

_____

Work/Training/Income Information

Current Household Income $ _____ ☐ Weekly ☐ Bi-weekly ☐Semi-Monthly ☐ Monthly ☐Yearly

Number of people living in this Household: Adults # _____ Children # _____ Total # _____

Is the Family currently enrolled in the Care4Kids Program? ☐ Yes ☐ No ☐Interested in applying

Primary Adult: Please check all that applies:

☐ Currently Employed ☐ Self Employed ☐In Training/School ☐ Looking for work ☐ Disabled/ Unable to work

Employer/School/Training Name: _____

Address: _____

Phone Number: _____ Schedule Hours _____ to _____ ☐ Hours Vary

Are you receiving: ☐State Welfare (TFA) ☐Unemployment ☐ SNAP (Food Stamps) ☐ Social Security ☐Workers Compensation

Spouse/Partner (if applicable): Please check all that applies:

☐ Currently Employed ☐ Self Employed ☐In Training/School ☐ Looking for work ☐ Disabled/ Unable to work

Employer/School/Training Name: _____

Address: _____

Phone Number: _____ Schedule Hours _____ to _____ ☐ Hours Vary

Are you receiving: ☐State Welfare (TFA) ☐Unemployment ☐ SNAP (Food Stamps) ☐ Social Security ☐ Workers Compensation

OFFICE USE ONLY

Date request form received: _____ Received by: _____

Date entered in ProCare: _____ Account Key: _____

Date enrollment offered: _____ Referred for ☐Infant/Toddler ☐School Readiness

Eligible by ☐ Income ☐ Other Factor: _____

HNH Staff: REV HNH 7.13.20

Dear Parent/Guardian/Foster Parent,

Thank you for choosing Hall Neighborhood House for your childcare needs. Please fill out the information on the reverse side of this form. Return or email form back to us and we will contact you when there is an opening for your child. When we schedule an appointment with you to enroll your child, please bring the following:

- $5 registration fee (*for new clients only)
- Child's Birth Certificate
- Child's Social Security Number
- Proof of medical insurance coverage
- Copy of the child's most recent physical (within last year)
- Medicine or Allergy Documentation (if applicable)
- Proof of income for the last four weeks
    - Pay stubs
    - State Welfare Certificate
    - Unemployment voucher
    - Worker's Compensation documentation
    - Social Security statement

We do not keep originals. Copies will be made of required documentation.

Please feel free to contact us if you have any further questions:

Tatiana Monteiro-Family Service Manager
tmonteiro@hnhonline.org
203.345.2048

Hector R. Burgos-Early Learning Program Director
hburgos@hnhonline.org
203.345.2052

EARLY LEARNING PHILOSOPHY STATEMENT

Hall Neighborhood House strives to provide children and families with the highest quality early childhood program through consistently implementing our core beliefs.

We believe that children learn in the context of relationships and interactions with adults and other children.

We believe that children learn through play and active exploration of their environment.

We believe that children can construct their own learning through investigations of their interests.

We believe that each child, parent, and teacher is a respected and valued member of our program community.

We believe that all teachers are professionals that work every day to facilitate children's learning and development.

We believe that families and teachers are partners in supporting the growth and development of children.

Early Learning Intake

Child's Name:	Date of Birth:	CHECKLIST

Primary Adult's Name: _____ **Phone #:** _____

Return Intake Application to: _____ **Phone #:** _____

1. Enrollment Documents:

- ☐ Complete and signed Intake Application (includes Family Handbook receipt signature page)
- ☐ Child's Official Birth Certificate
- ☐ Physical & Immunization Records (must be within the last 12 months & on CT State ED191 Form) Click here for Physical Form
- ☐ Child's Health Insurance Card
- ☐ Dental Assessment or ☐ Proof of Dental Appointment (Preschool children only) - ☐ Not applicable
- ☐ Two (2) proofs of address (Preschool children only) - ☐ Not applicable
- ☐ Completed and signed CACFP Income Eligibility Application Form (double check form for accuracy)
- ☐ Individualized Education Plan (Board of Ed. IEP) or Birth to Three (IFSP) - ☐ Not Applicable
- ☐ Custody Agreement - ☐ Not Applicable

2. Proof of family Income & Work Schedule:

- ☐ Pay stubs – covering four (4) consecutive weeks, or
- ☐ Most recent tax return (signed & filed) if self-employed, or
- ☐ Notarized letter stating income and work schedule, if paid in cash, or
- ☐ Unemployment compensation stub or printout from the Department of Labor, or
- ☐ Social Security (SSI) compensation, or
- ☐ DSS Budget Sheet or Notarized *"Unemployed Status Notification"* if not receiving unemployment compensation, or
- ☐ DCF stipend (for foster children only)

3. If applying for Care- 4-Kids (C4K) ☐ Not Applicable

- ☐ Letter from employer stating work schedule or copy of electronic timecard records, and
- ☐ C4K Application or Redetermination form Click here for C4K application
- ☐ C4K Parent Provider form Click Here for Provider Form

4. Health & Nutrition Forms (for children requiring medication or special menus at the center)

- ☐ Medication Administration Authorization form - ☐ Not Applicable Click Here for Med Form
- ☐ Asthma Action Plan - ☐ Not Applicable Click Here for Asthma Plan Form
- ☐ CACFP Food Allergies/restrictions form - ☐ Not Applicable Click Here for Food Restriction Form
- ☐ Allergies/ Anaphylaxis Emergency Care Plan - ☐ Not Applicable Click Here for Allergy Care Plan
- ☐ Child's medication (sealed & with up-to-date prescription label) - ☐ Not Applicable

OFFICE USE ONLY

FSC Appointment(s) Date/Time: _____ _____ _____

Notes:

_____

_____

_____

REV HNH 7.13.20

Hall Neighborhood House, Inc.
52 George E. Pipkin's Way, Bridgeport, CT 06608 ★ P: (203) 345-2000 ★ F: (203) 335-0475

Child's Name:	Date of Birth:	Intake & Enrollment

Emergency Contact & Authorized Pick-up

I understand that my child will not be allowed to leave the center with any person without written permission or personal contact from the parent or guardian and that such person must be at least 16 years old and provide picture identification (I.D.)

In case of an emergency, every attempt will be made to contact the parent/guardian. **Please indicate by checking the box next to the authorized pick-up persons who could be notified if the parent/guardian cannot be reached in the event of an emergency.**

Authorized Pick-up #1 Emergency Contact Person ☐

Name: _____ Date of Birth: _____

Relationship to the Child: _____

Cell phone:_____ Home phone:_____ Work phone:_____

Authorized Pick-up #2 Emergency Contact Person ☐

Name: _____ Date of Birth: _____

Relationship to the Child: _____

Cell phone:_____ Home phone:_____ Work phone:_____

Authorized Pick-up #3 Emergency Contact Person ☐

Name: _____ Date of Birth: _____

Relationship to the Child: _____

Cell phone:_____ Home phone:_____ Work phone:_____

Authorized Pick-up #4 Emergency Contact Person ☐

Name: _____ Date of Birth: _____

Relationship to the Child: _____

Cell phone:_____ Home phone:_____ Work phone:_____

Authorized Contact #5 Emergency Contact Person ☐

Name: _____ Date of Birth: _____

Relationship to the Child: _____

Cell phone:_____ Home phone:_____ Work phone:_____

Authorized Contact #6 Emergency Contact Person ☐

Name: _____ Date of Birth: _____

Relationship to the Child: _____

Cell phone:_____ Home phone:_____ Work phone:_____

Signature of Parent/ Guardian: _____ Date: _____

hnh **Early Learning Intake**

Child's Name:	Date of Birth:	Intake & Enrollment

Consents/ Permission Form

Photo/Video Consent ☐ Yes ☐ No Initials _____

I grant permission for photographs/ videos of my child to be taken & possibly used in HNH website, press releases, brochures, classwork, program portfolios, newsletters, site portraits

Field Trip/Playground Permission ☐ Yes ☐ No Initials _____

I grant permission for my child to be to be transported by HNH staff for field trips and walks off premises. Furthermore, I understand that except for walks around the premises, additional permission forms must be signed for each trip individually.

I grant permission for my child to use all the play equipment, materials and to fully participate in all activities and aspects of the program

Screening Consent ☐ Yes ☐ No Initials _____

I grant permission for my child to be screened at the center as required by state funding source and to meet health standards (Hearing, Vision, Dental and Developmental). The results of these screening will be shared with me and any concerns will be discussed.

Consent for Oral Hygiene Program Participation ☐ Yes ☐ No Initials _____

- For infants under 12 months, their teeth and gums will be wiped after each feeding with a disposable cloth or swab. This will help to remove the liquid that coats gums and teeth.
- For children over 12 months, they will be encouraged and assisted to brush their teeth after each meal. Individual toothbrushes and fluoride toothpaste will be provided. Parents are encouraged to make annual dental appointments for their children.

Statement of Parent Handbook Received

Parent Handbook Confirmation ☐ Yes ☐ No Initials _____

This is to confirm that I have received and reviewed the Hall Early Learning Parent Handbook and agree to abide by the policies & procedures set forth by Hall Neighborhood House.

Statement of Behavior Modification Policy Reviewed ☐ Yes ☐ No Initials _____

This is to certify that Hall Early Learning Center's Behavior Modification Policy explained in the parent handbook has been discussed with me.

Parent Authorization for Release of Information

I give permission to Hall Neighborhood House to request/exchange developmental, medical, dental and nutrition information with my child's physician, dentist, medical specialist, the Board of Education or Birth to Three Services.

Purpose:

1. To receive information required by the CT Office of Early Childhood to complete requirements of the physical and dental exams, i.e. lead, blood pressure, hemoglobin, growth, treatment needs, immunization updates, medical records.
2. To follow-up on referrals made for hearing, vision, growth, and other health concerns.
3. To receive information and follow-up on referrals made by Board of Ed Services (IEP) and Birth to Three (IFSP)

Information that is requested/ exchanged will allow Hall Neighborhood House/ Hall Early Learning Center to provide a comprehensive health and education program to the child and support parents in their roles.

I also give permission to the following person to have access to my child's file: _____

***** This form will be kept on file and will remain valid for the duration of my child's enrollment at Hall Early Learning Center *****

Signature of Parent/ Guardian: _____ Date: _____

hnh **Early Learning Intake**

Child's Name:	**Date of Birth:**	**Health**

Emergency Consent

I hereby grant permission for the staff of Hall Neighborhood House who are responsible for the care and education of my child to have access to my child's health information and to take whatever steps may be necessary to obtain emergency care **if warranted**. There steps may include but are not limited to the following:

1. The child will receive first aid or CPR from a member of the staff trained in first aid or infant/ child CPR procedures.
2. If your child shows suspicious signs of symptoms of short-term contagious illness, a trained staff member will evaluate the child. If the child is believed to be contagious, the parent/guardian will be contacted immediately to take the child home. The child and the staff member will remain in the sick child room until the child is picked up.
3. The staff will attempt to contact the parent/ guardian. If the parent/ guardian cannot be reached, the persons listed on the Emergency Information form will be contacted.
4. The school will not be responsible for anything that happens because of false information provided at time of enrollment.
5. The HNH staff will call 911 if necessary.
6. I give permission for my child to be transported by ambulance to the hospital. A staff member will accompany the child and the consent form for treatment to the hospital to prevent any delays in receiving treatment.
7. Any transportation expense incurred for medical treatment will be the responsibility of the parent/guardian.
8. The child will be transported to Bridgeport Hospital or nearest hospital in case of an emergency during a fieldtrip.

Physician/ Hospital Permission form to Administer Emergency Care

I understand that it may be necessary, on the advice of a physician licensed to practice in this state, for my child to receive emergency care of a physician or emergency care in a hospital. I realize that prior written consent is necessary, delay in treatment of the child may be harmful to the health of life of the child. I, therefore, authorize Hall Neighborhood House/ Hall Early Learning Center to consent on my behalf to treatment of my child for any condition suddenly arising which requires such treatment including medical and hospital treatment if a physician advises the same.

Signature of Parent/ Guardian : _____ Date: _____

List any medical conditions, medications, and/or special attention your child may require:

_____

_____

_____

_____

_____

Allergies: _____

Physician's Name: _____ **Phone:** _____

Dentist's Name: _____ **Phone:** _____

Insurance: ☐ State/Public ☐ Private Insurance Company/Policy Number: _____

☐ No Insurance

Copy goes to teacher

***** This form will be kept on file and will remain valid for the duration of my child's enrollment at Hall Early Learning Center *****

Child's Name:	Date of Birth:	Health

Health Assessment

CONFIDENTIALITY STATEMENT: *This information will only be shared with the Hall Neighborhood House Child Development staff and will be kept confidential unless the release is authorized in writing.*

Does child have any medical condition? ☐ Yes ☐ No If yes, explain _____

_____

Does child wear glasses? ☐ Yes ☐ No When was the last check up? _____

Does child have difficulty seeing? ☐ Yes ☐ No (*If yes, check what applies)* ☐ Squints ☐cross eyes ☐ look closely at books

Does child have problems with ears/hearing? ☐ Yes ☐ No If yes, explain _____

_____

Has child ever had a convulsion or seizure? ☐ Yes ☐ No If yes, when did it last happen? _____

What medicine does child take for seizures? _____

Is child taking any other medicine now? ☐ Yes ☐ No *(consent form must be signed to administer any medication in school)*

Does your child have any identifying marks (birthmark, etc.)? ☐ Yes ☐ No If yes, specify: _____

Did mother visit physician for regular prenatal care during pregnancy? ☐ Yes ☐ No

Did mother have any health problems during this pregnancy or during delivery? ☐ Yes ☐ No

If yes, explain: _____

Was child born more than 3 weeks early or late? ☐ Yes ☐ No Weight at birth: _____ lbs. ____ oz.

Did child or mother stay in hospital for medical reasons longer than usual? ☐ Yes ☐ No

If yes, explain:_____

Has child ever been hospitalized or operated on? ☐ Yes ☐ No If yes, explain: _____

Has child ever had a serious accident? (Broken bones, head injuries, fall, burns, poisoning) ☐ Yes ☐ No

If yes, explain:_____

Has the child experienced frequent:

☐ Sore throat ☐ Urinary infections ☐ Vomiting
☐ Stomach pain ☐ Trouble urinating ☐ Diarrhea
☐ Other: _____

By what age would you say your child began to (✓):	6m	9m	1yr	18m	2yr	3yr	4yr	5yr	Not applicable
Sit up without help	☐	☐	☐	☐	☐	☐	☐	☐	☐
Crawl	☐	☐	☐	☐	☐	☐	☐	☐	☐
Walk	☐	☐	☐	☐	☐	☐	☐	☐	☐
Talk	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tell you his/her name	☐	☐	☐	☐	☐	☐	☐	☐	☐
Understand what is said to him/her	☐	☐	☐	☐	☐	☐	☐	☐	☐
Toilet trained	☐	☐	☐	☐	☐	☐	☐	☐	☐

***** This form will be kept on file and will remain valid for the duration of my child's enrollment at Hall Early Learning Center *****

Copy goes to teacher

Early Learning Intake

Child's Name:	Date of Birth:	Therapeutic

Child's Ethnicity/Race

Ethnicity (check one):

☐ Hispanic (a person of Cuban, Puerto Rican, South/Central America or other Spanish Culture or Origin)
☐ Not Hispanic

Race (check one or more):

☐ American Indian ☐Asian ☐Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White
☐Other: _____

Child/ Family Information

We believe that families and teachers are partners in supporting the growth and development of children. The information below will help us understand your child and better respect the values of your family.

Has your child attended childcare before? ☐ Yes ☐ No

If yes, How was his/her experience: _____

When you think about your child, what makes you proud?_____

What is your child passionate about? _____

What do your child cry about at home? _____

Do you have any suggestions on how to best connect with your child? _____

What helps to motivate your child to do his/her best?_____

What triggers frustration or withdrawal with your child? _____

What are things I should do and things that I should avoid with your child? _____

Child's primary language spoken at home: _____

What country are you, your parents, or grandparents from? _____

What are special holidays your family observes and celebrate? _____

We love to share the diversity of the children at the center. Will you be willing to share some of your family's culture by contributing stories, clothes, songs, recipes, music with the children in the classroom? Yes No

Family Interest Survey

Hall Neighborhood House Child Development Program wants to make sure that you know the resources and services that are available to you within our community. Working together, we can take advantage of resources available to get the information you need. On the following list there are many topics that parents have expressed an interest in knowing more about. Please **CHECK** the topics that most interest you.

☐Birth to Three	☐First Aid and CPR Certification	☐Job Related Skills
☐Child Care Assistance Program (Care 4 Kids)	☐Food and infant formula assistance such as WIC	☐Medical Help
☐Children's Behavior, Growth and Development	☐Food stamps/ cash assistance	☐Mental Health Services
☐Dental Help	☐GED (General Education Certificate)	☐Nutrition/Meal Planning
☐Energy Assistance	☐Health Insurance (Husky/ Charter Oak)	☐Transportation
☐English Classes (ESL)	☐Home ownership Assistance	☐Domestic Abuse
☐Family Counseling	☐Housing	☐Other:

Signature of Parent/ Guardian: _____ Date: _____

***** This form will be kept on file and will remain valid for the duration of my child's enrollment at Hall Early Learning Center *****

Copy goes to teacher

hnh Early Learning Intake

Child's Name:	Date of Birth:	Financial Worksheet

CONFIDENTIAL

***** *Attach all income your family receives including **gross earnings** **before taxes & deductions*** *****

Is the above child placed with you by DCF? ☐ No ☐ Yes (**if yes, this is a "family of one 1" - do not complete household information below)**

Do you receive Care-4-Kids? ☐ Yes ☐ No ☐ Pending C4K Family ID#: _____

Do you receive Food Stamps? ☐ Yes ☐ No ☐ Pending If yes, SNAP case number: _____

Do you receive Cash Assistance? ☐ Yes ☐ No ☐ Pending If yes, TFA case number: _____

List the ADULT(S) residing in the household (18 years-old or older) - **including yourself**

Name	Relationship to Child	DOB	Working Yes/No	In School /Training Yes/No	Unable to work/Disabled Yes/No

List OTHER CHILDREN in the Household (Under 18 years-old)

Name	DOB	Name of School	Current Grade

I certify that my family consists of: _____ Adult(s) + _____ Children = Total Family Size: _____

Signature of Parent/ Guardian (1): _____ Date: _____

HALL EARLY LEARNING CENTER ENROLLMENT OFFICE USE ONLY

Income Verification: I certify that I have received and examined the following income documentation for the above family

Please check all items that apply:

- ☐ Pay Stubs
- ☐ TFA cash assistance budget sheet
- ☐ Income Tax return (signed & dated)
- ☐ Social Security income
- ☐ Letter of employment verification/schedule
- ☐ Notarized letter of self-employment /schedule
- ☐ Notarized unemployed status certification
- ☐ Unemployment Compensation
- ☐ Other_____

Total family annual income: $_____ ▪Weekly x52 ▪Bi-Weekly x26 ▪Semi-Monthly x24 ▪Monthly x12

This Income was earned from: _____to_____ or Date of Letter/ Tax Return:_____

(Pay date range from first to last paystubs

Enrollment Staff Signature:_____ Date:_____

** ***This information MUST be updated yearly and/or whenever requested by family*** **

Child's Name:	Date of Birth:	Financial

CONTRACT OF SERVICES

Parent/ Guardian's Name (print): _____

Address: _____
No. & Street City State Zip

By signing this contract, I agree to pay for services rendered by HNH Early Learning Program. The program will determine my fee within the guidelines set by the State of Connecticut Department of Education. Care4Kids may adjust my fee, according to their guidelines.

My family's share of the cost of services provided, including meals, is $_____ per week.

Check if discount applied: ☐25% Sibling ☐100% Staff **C4K:** ☐No ☐Pending ☐Yes Cert#:_____

This calculation covers the contract period from _____ to _____
(Yearly for CDC IT & SR PS. If C4K, list date range on certificate)

- I understand that weekly tuition is due in advance on the Friday before the week services are to be rendered. Fees are considerate late if payment is not received by drop-off time on Monday of the week services are being rendered. Accepted methods of payment include cash, personal check, money order, or credit card via Tuition Express.
- I understand that there are no tuition reductions, credits or refunds given for school closings and absences
- If my child is absent for 15 consecutive days with no notification, I understand that my child may forfeit his/her slot.
- A late fee of $5.00 per day may be charged for each date of late payment.
- A $1.00 per minute fee will be charged for late pickup. There is a 5-minute grace period; however, if there is 6 minutes delay the charge will be applied from the first minute. A child is considered late if picked up after the center's closing time.
- Continual late payments may result in the closure of your child's enrollment from the program
- I understand that failure to complete the total payment agreed upon may result in legal collection procedures; all additional costs of which will be my responsibility.
- I agree to comply with annual income verification/ eligibility redetermination which will be completed once per year for Child Day Care (infants/toddlers), School Readiness (preschool), CACFP (food program) and Care-4-Kids (childcare subsidy program)
- I understand that I reserve the right to request a review of my family income at any given time and have my fee adjusted
- I understand that Hall Early Learning reserves the right to review parent/ family income information at any given time and make tuition adjustments accordingly.

My child's hours are from _____ to _____

The statements made about my family's income are true and correct to the best of my knowledge. I have entered into this agreement with honesty and integrity and understand that false information or omission of information may lead to interruption or services or dismissal of my child from the program. I acknowledge that I have received a copy of this contract, have reviewed it and understand the policies and procedures covering this contract. I have accepted its terms and no future reminders/ bills need to be issued.

Signature of Parent/ Guardian: _____ Date: _____

Program Staff Signature: _____ Date: _____

***** Must be updated yearly or as specified by Care 4 Kids****

Hall Neighborhood House
Early Learning Program
52 George E Pipkin's Way Bridgeport CT 06608

hnh **Early Learning Intake**

Child's Name:	**Date of Birth:**	**Nutrition**

Nutrition Assessment

Click Here for Food Restriction Form

Does your child have any food allergy or food intolerance? ☐ Yes ☐ No *(If yes, fill out CACFP Allergy/Restriction form)*

Are there any foods your child should not eat for religious of personal reasons? _____

Is your child on a special diet now? ☐ Yes ☐ No
If yes what is the reason? _____

What foods do your child specially likes?_____

Are there any foods your child dislikes? _____

Do you have any food or nutritional concerns about your child? _____

Does your child have problem chewing or swallowing? _____

Does your child eat or chew things that are not food? _____

Does your child often have diarrhea or constipation? _____

At which meal does your child eat the best? _____

Please describe your child's eating behavior:

☐ Feeds self, using fork or spoon ☐ Picky eater ☐ Eats a variety of foods ☐ Socializes with others during mealtimes

Infant Only

Is your child on formula or breast milk? _____

Does your child require a special feeding accommodation? _____

How many ounces does your child take during a feeding? _____

Do you feed on a schedule or on demand? _____

Additional Comments:

_____

_____

_____

_____

Signature of Parent/ Guardian: _____ Date: _____

Copy goes to teacher