CHILD'S NAME__________________ START DATE____________________

WESTBAY CHILDREN'S CENTER

Child Information Tour

Parent Name: ______________________________

Child's Name: ______________________________

DOB: ________________________

Phone Number: ______________________________

Email: ______________________________________

Schedule: ___________________________________

Special Concerns?

____

____

Office only

INTRODUCTION/SITE VISIT

_____ Tour of facility by Sr. Manager/Program Specialist

_____ Review Fee Schedule

_____ Review Packet provided to parent

Binders

_____Child Info Sheet (Emergency Contact Binder)

_____ Tracker Form

_____Meal Form

Preparing For First Day

_____Enrolled in DHS

_____ Enrolled in Procare

_____Send Financial Agreement to Finance office

_____Pupil Form for teacher

_____ Child Info Sheet

_____Allergy Update Chart

_____ Door Code

_____Parent Mailbox

Follow UP

_____ Happily Enrolled

_____Did not Enroll

Because____________________________________

Staff Initials _________________Date ____________

Program: Toddler_____ Preschool____
Pre-k 1____ Pre-K 2_____School Age_____

Section 1 – Medical

_____ Immunizations/Current Physical/ Lead Screening

_____ Emergency Treatments Authorization

_____ Health History Form

Section 2- Westbay Application

_____ Application for Enrolment

_____ Authorization for Release

_____ Pupil Information Form

Section 3 – Finance

_____ Establish rate/Financial Agreement

Section 4- Parent Authorization

_____ Consent Form

_____ Kids Connect Consent Form

_____ Schedule of Enrollment

Section 5- Child's Incident Reports

Section 6- Assessments

Payment Method

_____ Credit Card Authorization

_____ Cash

_____ Collect $50 application fee

_____ Collection first week tuition

Weekly Billing: ____________________

DHS#: __________________________

REVISED: ____________

ALL APPLICANTS MUST BE ACCOMPANIED BY:

***$50.00 REGISTRATION FEE** *** FIRST WEEK CHILD CARE PAYMENT**

WESTBAY CHILDREN'S CENTER APPLICATION	
APPLICANT INFORMATION	
Child's Name:	
Date of birth:	SSN:
PARENT OR GUARDIAN 1	
Name:	Relationship to child:
Home Street Address: City: State: Zip:	
Cell phone #	Email:
Work Schedule:	Work Phone #
Employer:	
PARENT OR GUARDIAN 2	
Name:	Relationship to child:
Home Street Address: City: State: Zip:	
Cell Phone #	Email:
Work Schedule:	Work phone #
Employer:	
QUESTIONS	
How did you hear about our program?	
Is your child transferring from another program? If so, why?	
Has your child attended preschool before? If so, where?	
SCHOOL AGE ONLY	
Does your child attend a public school? If so, where?	
CIRCLE THE DAYS YOUR CHILD WILL BE ATTENDING?	
Monday Tuesday Wednesday Thursday Friday	
Hours your child will be attending? Date your child will start at Westbay Children's Center?	
SIGNATURES	
*I certify that the information provided in this application is true.	
Signature of Parent or Guardian:	
Date:	

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AUTHORIZATION FOR RELEASE

Child's Name: ______________________________ Date: ____________________

Our security door requires A 4 digit code to gain entry to our school. Please indicate your 4-digit code below and list the people that you authorize to pick up your child(ren) from school. **By listing a person here you are authorizing Westbay Children's Center to release your child to that person at any time**. Each escort can have their own pin # to enter the school **HOWEVER**, access to the school should only be given to close family members/friends. We also encourage you to select a one-word phone code for security purposes. You may be asked for your code to verify that it is you calling to authorize a pick up change. You may add or delete names at any time. Thank you for your cooperation with this important school policy.

Legal Guardians

Name: ____________________ Name: ____________________

Relationship To Child: ______________ Relationship To Child: ______________

4-Didgit pin # ____________________ 4-Didgit Pin # ____________________

Authorization Escorts

Name: ____________________ Name: ____________________

Phone Number: ______________ Phone Number: ______________

Relationship To Child: ______________ Relationship To Child: ______________

Pin # / Special Instruction: ___________ Pin # / Special Instruction: ___________

Name: ____________________ Name: ____________________

Phone Number: ______________ Phone Number: ______________

Relationship To Child: ______________ Relationship To Child: ______________

Pin # / Special Instruction: ___________ Pin # / Special Instruction: ___________

Phone Code: (so we can identify you when you call with instructions): ______________

- Any change of escorts must be made in writing by the enrolling parent
- It is the enrolling parent's responsibility to provide copies of legal notices to the center (i.e Custody Orders, Restraining Orders, etc.)
- All escorts must provide a photo identification at the front office before your child's released
- Please sign to indicate you have read and understand this policy.

Signature: ______________________________ Date: ____________________

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PUPIL INFORMATION FORM

We are interested in meeting the needs of your child. This additional information will help us achieve this goal and devise a more individual program for your child.

Child's Name______________________________ Date of Birth____________

- ☺ Name your child responds to (nickname)__________________________
- ☺ Favorite toy_______________________ Favorite food(s)______________________
- ☺ Is there a special friend or playmate? _____ Name___________________________
- ☺ Do you have any pets? ____ Type and name(s)________________________________

SLEEPING

1. What time does your child usually go to bed at night? _________________
2. Get up in the morning? _______________
3. Does your child sleep with a special toy or security blanket? _____________
4. Does your child usually nap or rest during the day ____ for how long? ________

SPEECH/LANGUAGE

1. What is the primary language spoken at home? _________________________
   - ☺ If English is not your primary language, does your child understand English? _____, Speak English? ________
2. Does your child speak clearly so that others can understand him/her? ____________
3. Do you have any concerns about your child's speech or language development? (If so, specify)____

SELF-HELP

1. Can your child dress self? ____ Manage buttons? ____ Zippers? ____
2. Does your child tell an adult when he/she needs to go to the bathroom? ______
   - ☺ Child's words for urination__________ bowel movement______________

SOCIAL/EMOTIONAL

1. Does your child have any particular fears? ____ (If so, specify)____________________
2. Have any of the following issues recently occurred in your family?
   ___serious family illness ___death of a loved one ___death of a pet
   ___ separation or divorce ___new home ___birth of a sibling
   ___other (specify)____
3. How would you characterize your child (check all that apply) ___assertive___aggressive
   ___ shy ___ withdrawn ___ a leader ___ a follower ___plays alone ___ seeks others
4. Are there any activities common to your child's age group that your child has no apparent interest in? ____

OTHER

1. What holidays or cultural celebrations does your family celebrate? ______________
   ____
2. Are there any celebrations that you object to? (specify)_________________________
3. Is there any other information we should have to help plan for your child? _________
   ____

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AUTHORIZATION FOR EMERGENCY TREATMENTS

I hereby authorize the Westbay Day Care Center to arrange for medical examination and/or treatment of my child ____________________ should an emergency arise at school or on a field trip. It is understood that a conscientious effort will be made by the school to contact me at the emergency numbers I have provided before any medical action is taken. (If the need arises), I would prefer to have my child ____________________ taken to __________________Hospital. (Note: Choice of hospital may be limited by service of local rescue and/or hospital availability.)

In addition, if your child has a medical emergency at Westbay Children's Center or on a field trip, we would like to be fully informed regarding the medication your child is currently taking.

Please list any prescribed medications, including the ones taken at home. Should this information change, keep us informed so we can keep our records up to date.

Thank you~

MEDICATIONS			
Child's Name		Date	
MEDICATION	**REFILLS**		
Medication Name	Times	Time/s Given	Dose

Signature of Parent/Guardian____ Date_____

Revised 7/2017

School Name & Address:	Westbay Children's Center 22 Astral St. Warwick, RI 02888
Grade: ____________	

STATE OF RHODE ISLAND
SCHOOL PHYSICAL FORM

Health Care Provider Name and Address:
Phone:

This form may substitute for any district-issued form. All districts must accept this form. General health examinations shall be documented in a standardized format with one copy available from the Rhode Island Department of Health or in any such format that captures the same fields of information (R16-21SCHO Section 8.4)

Student Name: Last	First	Middle	Date of Birth	Sex

Address: Street	Apt #	City	State	Zip Code	Home Phone

PLEASE COMPLETE ALL INFORMATION BELOW (May attach immunization transcript).

IMMUNIZATIONS	Please enter dates in MM/DD/YYYY format				
Hepatitis B					
Diphtheria-Tetanus-Pertussis DTaP < 7 years					
Pneumococcal Conjugate PCV					
Polio					
Haemophilus Influenzae Type B Hib					
Measles-Mumps-Rubella MMR					
Varicella			☐ Student has history of varicella disease		
Tetanus-Diphtheria-Pertussis Tdap/Td ≥ 7 years					
Rotavirus					
Hepatitis A					
Meningococcal					
HPV					
Influenza					

Medical Exemption:

☐ Hep B ☐ DTaP ☐ PCV ☐ Polio ☐ Hib ☐ MMR ☐ Varicella ☐ Td/Tdap ☐ Rotavirus ☐ Hep A ☐ Mening ☐ HPV ☐ Influenza

PHYSICAL EXAMINATION

Date of PE ____/____/____ Height __________ Weight__________ BP__________

PLEASE NOTE ANY HEALTH PROBLEM, CHRONIC HEALTH CONDITION OR DISABILITY THAT MAY AFFECT BEHAVIOR OR HEALTH AT SCHOOL:

1. ASTHMA: No☐ Yes☐ If yes, complete an *Asthma Action Plan* (www.health.ri.gov/publications/actionplans/2012Asthma.pdf)

2. ALLERGIES: No☐ Yes☐ (Please explain) ______________________________ EPINEPHRINE AUTO-INJECTOR REQUIRED: No☐ Yes☐

If student has a severe allergy (food, insect, other) complete a *Food Allergy& Anaphylaxis Emergency Care Plan* (www.foodallergy.org/document.doc?id=234)

3. DIABETES: No☐ Yes☐ If yes, complete a *Physicians Order Form For Students With Diabetes* (www.health.ri.gov/forms/school/PhysicianOrdersForStudentsWithDiabetes.pdf)

4. OTHER: ____

Treatment Plan: ____

RESTRICTIONS: Can participate in physical education/sports: Fully☐ With limitation☐ ______________________

MEDICATION (REQUIRED AT SCHOOL): No☒ Yes☐ (Please list) ______________________

Other medication(s) that may affect behavior or health at school: ______________________

LEAD SCREENING (Required for children < 6 years old) Student is in compliance with lead screening requirements: Yes☐ No☐	SCOLIOSIS SCREENING Yes☐ No☐		VISION SCREENING (Children entering Kindergarten) ☐ Passed Screening ☐ Screened & referred for comprehensive exam ☐ Referred for comprehensive exam, but not screened	
TUBERCULOSIS (If required by school district) Date of TB test:			Screening / Referral Date:	Comprehensive Exam Date:

HEALTH CARE PROVIDER SIGNATURE: ______________________ DATE: __________

PRINT NAME: ______________________

HEALTH HISTORY OF CHILD

Child's Name: ____

Do you have medical coverage for your child? _______________
Name of Medical Coverage: __________________ Coverage #_______________

Name of child's Physician: _____________________ Date of last visit _________
Address __________________________________ Phone # __________

Name of Dentist: ___________________________ Date of last visit _______
Address __________________________________ Phone #_____________

Does your child have any allergies? Yes ____ No ____If so list and sign permission for it to be posted in the classroom __________________________________
Signature: ______________________________ Date: _________________

Has your child had any childhood illnesses/diseases? _____ If so, list all types and dates: ____

Does your child have any handicaps or special needs? _____If so, please describe:
____

Does your child take medication on a regular basis? _______If so, list below:

Name of medication	Daily dosage		Name of medication	Daily dosage

Has your child ever been hospitalized? _____ If so, list reason:

Reason for hospitalization	Date of admission	Length of stay

Is there anything "special" we should know about your child, which would help in caring for him/her? ____
____

SIGNATURE OF PARENT/GUARDIAN______________________ Date_______

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Westbay Children's Center

Photo Permission

I, ______________________________, give permission for my child, ______________ to have photographs and / or video taken during different activities and field trips at / with Westbay Children's Center. Photos/ videos may be used in the classroom.

______________________________ ______________________________

Parent / Guardian Signature Date

Website / Facebook Permission

I, ______________________________, give permission for my child's photographs/ videos to be used on the Westbay Children's Center Facebook page, news media (i.e. Newspaper, television) and center website, www.westbaychildrenscenter.com.

______________________________ ______________________________

Parent / Guardian Signature Date

Sunscreen Permission

I, ______________________________, give permission for staff of Westbay Children's Center to re-apply sunscreen to my child throughout the school day as necessary.

______________________________ ______________________________

Parent / Guardian Signature Date

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Kids Connect

CONSENT TO PARTICIPATE

Dear Parents,

We partner with the Executive Office of Health & Human Services in Rhode Island to provide Kids Connect in our program. This program allow us to provide the extra support needed for every child to successfully navigate our program.

Through this partnership, we are able to provide a Therapeutic Integration Specialist (TIS) and a clinician in your child's classroom. Our clinician prepares an individualized plan for successful integration into our program and works with our staff to support the needs of each child.

Based on classroom observations, previous experiences, developmental concerns, social or emotional concerns, or referrals from outside agencies, we may identified that your child could benefit from additional support. In the event that it becomes necessary, we would plan to meet with you to discuss your child's participation in this program.

We ask each family to sign this form to show that you understand the benefits of this program and would be willing to consider participation if needed.

If you have any concerns or questions, please contact Shannon Meinel at 401-463-6620.

Should the needs arise, I understand the Kids Connect program as described above. I agree to begin the process for my child to participate in Kids Connect.

____
Child's Name

______________________________ ____________________
Print Name Date

______________________________ ____________________
Parents Signature Date

For office use: Referral ______ IEP _______ IFSP ______ Past Exclusion ______

Westbay Community Action

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MEAL BENEFIT FORM for Child Care

Discharge Date: ______

PART 1. CHILDREN IN DAY CARE

Names of all children in care (First, Middle Initial, Last)	√ if Foster Child	√ if Homeless, Migrant or Runaway	If any member of your household receives Supplemental Nutrition Assistance Program (SNAP) or RIWorks, provide the name and full case number for the person who receives benefits. NAME: ______ CASE #: ______ If no one receives these benefits, skip to Part 2.

PART 2. TOTAL HOUSEHOLD GROSS INCOME
YOU MUST TELL US HOW MUCH AND HOW OFTEN

1. Name (List everyone in household, including foster children)	2. Gross income and how often it was received *Examples: $250/monthly $400/twice a month $125 every other week 190/weekly*				3. Check if NO income
	Earnings from work before deductions	Welfare, Alimony, Child Support	Pensions, Retirement, social security	Other	
1.					☐
2.					☐
3.					☐
4.					☐
5.					☐
6.					☐
7.					☐
8.					☐
9.					☐

PART 3. SIGNATURE AND SOCIAL SECURITY NUMBER (ADULT MUST SIGN)

An adult household member must sign the application. If Part 2 is completed, the adult signing the form must also list the last four numbers of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this form.)
I certify (promise) that all information on this application is true and that all income is reported. I understand that the childcare program will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, I may be prosecuted.

Sign here: ______________________ Date: __________

Social Security Number (last 4 numbers only): * * * - * * - _ _ _ _ ☐ I do not have a Social Security Number

PART 4. CHILDREN'S RACIAL AND ETHNIC IDENTITIES (OPTIONAL)

Choose one ethnicity:
☐ Hispanic or Latino ☐ Not Hispanic or Latino
Choose one or more (regardless of ethnicity):
☐ Asian ☐ Black or African American ☐ American Indian or Alaskan Native ☐ Native Hawaiian or Other Pacific Islander ☐ White

DON'T FILL OUT THIS PART. THIS IS FOR OFFICIAL USE ONLY.

Income Conversion: Weekly X 52, Every 2 Weeks (bi-weekly) X 26, Twice A Month X 24, Monthly X 12

Total Income: ________ Per: ☐ Week, ☐ Every 2 weeks, ☐ Twice a Month, ☐ Month, ☐ Year
Household size: ______ Categorical Eligibility: SNAP/RIWorks ___ Foster Child: ____ Homeless ___ Migrant ___ Runaway ___

Eligibility: Free ____ Reduced ____ Denied ____ Reason: ______________

Determining Official's Signature: ______________________ Approval Date: __________

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Westbay Children's Center
22 Astral Street
Warwick, RI 02888
401-463-6620

Schedule of Enrollment for U.S Department of Agriculture (USDA) Child and Adult Care Food Program

Name of Child(ren):______________________________

____

	Monday	Tuesday	Wednesday	Thursday	Friday
Hours In Care					

Please check off the meals your child should receive each day while in childcare.

Breakfast					
Lunch					
Snack					

______________________________ ______________________________
Parent / Guardian Signature **Date**

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Westbay Community Action, Inc.
TRACKER INTAKE FORM

Complete_____ Incomplete_______
Date Returned to DD_____

Social Security Number	Date of Service	Site Code	Staff Code	Service Code (s)

Last Name	MI	First Name	DOB (M/D/Y)	Head	Relation
				Y / N	

Street Address	City	Zip Code	Phone Number
			(H)
			(C)

Gender
- ☐ Female
- ☐ Male

Disabled
- ☐ Yes
- ☐ No

Eth. Background
- ☐ White
- ☐ Black
- ☐ Native American
- ☐ Hispanic
- ☐ Asian/Pac. Isl
- ☐ Aleut
- ☐Eskimo

Food Stamps/SNAP
- ☐ Yes $_______
- ☐ No

Veteran
- ☐ Yes
- ☐ No

Farmer
- ☐ Yes
- ☐ No

Primary Lang.
- ☐ English
- ☐ Spanish
- ☐ French
- ☐ Portuguese
- ☐ Cambodian
- ☐ Laotian
- ☐Other_______________

Health Insurance
- ☐ Medicaid
- ☐ Medicare
- ☐ Private:__________
- ☐ Self Insured
- ☐ Rite Care
- ☐ Other__________
- ☐ No Insurance

Household Information

Number in Family_______

Household Type
- ☐ Single Parent Female
- ☐ Single Parent Male
- ☐ Two Parent
- ☐ Single Person
- ☐ Couple
- ☐ Foster
- ☐ Other______________

Marital Status
- ☐ Single
- ☐ Separated
- ☐ Married
- ☐ Widowed
- ☐ Divorced

Education
- ☐ 0-8
- ☐ 12+
- ☐ 9-12
- ☐ College
- ☐ HS Grad / GED

Source of Income
- ☐ Employment
- ☐ Unemployment
- ☐ Social Security
- ☐ TANF/RI Works
- ☐ GPA
- ☐ SSI / SSDI
- ☐ Pension
- ☐ Disability
- ☐ Other_________

Frequency of Income
- ☐ Weekly _______
- ☐ Bi-Weekly_______
- ☐ Monthly _______
- ☐ Quarterly _______
- ☐ Annually _______

Total Mthy. Income from all Sources.

$________________

Housing Status
- ☐ Home Owner
- ☐ Rental
- ☐ With Family
- ☐ Subsidized Rental
- ☐ Homeless with Roof
- ☐ Homeless without Roof
- ☐ Living with Friends relatives
- ☐ Shelter
- ☐ **Mthy. Payment$**_____

Other Household Members

Name	Social Security	Rel.	DOB	Gender	Educ	Eth	Income	SVC code	Date

Did you file a Tax return? Y/ N **If yes, did you receive a EITC tax credit? Y/N**

WCA Staff____ Date_______________________________

Client Signature____________________________________ Date_______________________________

CREDIT CARD AUTHORIZATION FORM

I AUTHORIZE WESTBAY COMMUNITY ACTION, INC. TO CHARGE MY INVOICES TO MY CREDIT CARD. WESTBAY COMMUNITY ACTION, INC. OR I MAY TERMINATE THIS AGREEMENT BY WRITTEN NOTICE FROM EITHER PARTY TO THE OTHER.

CARDHOLDER'S INFO:	
Cardholder's Name	
Cardholder's Home Address	
Cardholder's Billing Address	

CREDIT CARD INFORMATION	
Card #	
Expiration Date	
Security Code	
Type of Card	Master Card ____ or Visa Card ____ Other ____

SIGNATURE & DATE OF CARDHOLDER			
Signature		Date	

PAYMENT INFORMATION (TO BE COMPLETED BY OFFICE)			
Child's Name		Weekly Charge	

Completed forms may be returned to:

Westbay Children's Center
22 Astral Street
Warwick, RI 02888

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