Parent/Guardian Information

Registration Date:________

Mother/Guardian First Name: _______________ M.I.___ Last Name: ________________________________

Address: ____

Occupation: ________________________________ Home Phone: ________________________________

Employed By: ______________________________ Office Phone: ________________________________

Custodial Parent (If married, mark both parents) Email:

Marital Status: Married -Single - Divorced - Separated - Widowed **Explain here**

May we take and maintain a photo of you for security purposes? yes / no

Father/Guardian First Name: _______________ M.I.___ Last Name: ________________________________

Address: ____

Occupation: ________________________________ Home Phone: ________________________________

Employed By: ______________________________ Office Phone: ________________________________

Custodial Parent (If married, mark both parents) Email: ____________________________________

Marital Status: Married - Single - Divorced - Separated - Widowed **Explain**___ _______________

May we take and maintain a photo of you for security purposes? **yes / no**

Child Information

1st Child First Name: ______________________ M.I.___ Last Name: ________________________________

Ethnicity/ Race: ______________________ Grade/Class:________________________________

Gender: Date of Birth:______________ Schedule: ________________________________

List any existing medical conditions, medication and/or special attention your child may require?

____

Allergies: ____

Pediatrician's Name: ____ Phone: ______________________

Address: ____

Primary Language Spoken at Home: English Spanish Other:____

Ethnicity: Hispanic - Non-Hispanic Latino - I would rather not say

Race: White - Alaskan Native - Asian - American Indian - Black or African American - Native Hawaiian Other Pacific Islander I would rather not say

Child Information - Continued

2nd Child First Name: ______________________ M.I.___ Last Name: ________________________________

Ethnicity/ Race: ______________________ Grade/Class:________________________________

Child's Address: ____

Gender: Date of Birth: _____________ Schedule: ________________________________

List any existing medical conditions, medication and/or special attention your child may require?

____

Allergies: ____

Pediatrician's Name: ____ Phone: ____________________

Address: ____

3rd Child First Name: ______________________ M.I.___ Last Name: ________________________________

Ethnicity/ Race: ______________________ Grade/Class:________________________________

Child's Address: ____

Gender: Date of Birth:_____________ Schedule: ________________________________

List any existing medical conditions, medication and/or special attention your child may require?

____

Allergies: ____

Pediatrician's Name: ____ Phone: ____________________

Address: ____

4th Child First Name: ______________________ M.I.___ Last Name: ________________________________

Ethnicity/ Race: ______________________ Grade/Class:________________________________

Child's Address: ____

Gender: Date of Birth: _____________ Schedule: ________________________________

List any existing medical conditions, medication and/or special attention your child may require?

____

Allergies: ____

Pediatrician's Name: ____ Phone: ____________________

Address: ____

Emergency Contacts & Authorized Pickup Persons:

1st Contact/Pick Up Name: ____ Phone:_ _________________

Relationship to the Child: ___________________________

Able to pick up all children in the family

Not able to pick up the following children:____

2nd Contact/Pick up Name: ____ Phone: _________________

Relationship to the Child: ___________________________

Able to pick up all children in the family

Not able to pick up the following children:____

3rd Contact/Pick Up Name: ____ Phone:_ _________________

Relationship to the Child: ___________________________

Able to pick up all children in the family

Not able to pick up the following children:____

4th Contact/Pick Up Name: ____ Phone:_

Relationship to the Child:

Able to pick up all children in the family

Not able to pick up the following children:

PERMISSIONS

1. **I DO/ DO NOT** GIVE PERMISSION FOR MY CHILD TO USE ALL OF THE PLAY EQUIPMENT AND PARTICIPATE IN ALL ACTIVITIES OF THE PROGRAM.
2. **I DO / DO NOT** GIVE PERMISSION FOR MY CHILD TO BE INCLUDED IN EVALUATIONS AND PICTURES CONNECTED WITH THE LEARNING CENTER PROGRAM.
3. **I DO / DO NOT** GIVE PERMISSION FOR MY CHILD TO INTERACT WITH ANY VOLUNTEERS WHO MAY BE INVOLVED IN THE PROGRAM.
4. **I DO / DO NOT** GIVE PERMISSION FOR MY CHILD TO BE TRANSPORTED TO ____________HOSPITAL AND ADMINISTER APROPRIATE TREATMENT INCASE OF AN EMERGENCY.
5. **I DO / DO NOT** GIVE PERMISSION FOR MY CHILD TO BE TAKEN TO AN OFF- SITE LOCATION TO PARTICIPATE IN ACTIVITIES OF THE PROGRAM.
6. **I DO / DO NOT** AGREE TO BRING IMMUNIZATION RECORDS OF MY CHILD BEFORE HIS OR HER FIRST DAY OF CLASS.
7. **I DO/DO NOT** ALLOW THE CENTER TO WASH MY CHILD'S BLANKETS AND SHEETS.
8. **I DO / DO NOT** GIVE PERMISSION FOR MYSELF AND MY CHILD TO HAVE PICTURES TAKEN AND OR BE VIDEO TAPPED. IF PICTURES AND VIDEOS ARE USED IN THE MEDIA ONLY FIRST NAMES MAY BE USED.

______________________________________ ______________________
PARENT / GUARDIAN SIGNATURE DATE

______________________________________ ______________________
REPRESENTATIVE SIGNATURE DATE

AGREEMENT FOR CHILDCARE

Tuition / Payment Information: **Child's Name:**______________________

Current Tuition Amount: ______________________ [ ] Weekly [ ] Bi-Weekly [x] Monthly [ ] Other________

Please outline below payment arrangements and if a child is self-pay or CYFD.

____

____

____

Payment is due to the provider in advance of care and is due by the 5th of the month. If the 5th of the month falls on a weekend or a holiday, then the payment is due on the next business day. Accepted methods of payment include money order, check, credit or debit card. NO cash is accepted. If a personal check is returned due to lack of funds, the parent/guardian must pay a $25 returned check fee. If a check is returned, ALL future payments must be made via credit card or money order.

If a payment is not made by the 5th of the month a late payment fee of $25 will apply. The child cannot attend until the full payment plus the late fee is paid.

If parent is going to be late picking up child, Parent must contact and notify the Catholic Charities Children's Learning Center (CLC). A late pick up fee of $1 per minute will be charged.

There is an annual registration fee charge of $50. It will be charged July 1st regardless of child start date.

CYFD Payments
If you are eligible for CYFD Child Care Assistance you are responsible for any co-pays required by the CYFD contract. All of the above rules apply to payments by CYFD. There are NO exceptions.

Holidays and Other Closures
Catholic Charities Children's Learning Center (CLC) will be closed on the following holidays and closure days:
Fourth of July, Memorial Day, Veterans Day, Thanksgiving, the day after Thanksgiving, Christmas Eve and Christmas Day, Presidents day, Good Friday, Martin Luther King Jr, New Year's Day, Independence Day, Labor Day, Veterans Day, and 2- 3 in-service trainings (2 program training and 1 agency training).
Parents are expected to pay for care those holidays and closure days.

CLC does not prorate monthly fees due to a child's absence regardless of the reason including a child's illness or other family circumstances that keep the child from attending. CLC does not prorate monthly fees for federal or state holidays. CLC does not prorate CYFD co-pays. In the event of an unscheduled closure of the CLC, CLC will prorate fees for the days closed. In the

event that the CEO determines that the entire agency will be closed additional days around the Christmas holiday, CLC will prorate fees for those days closed.

When a child will be out for vacation or illness parents are expected to make every effort to give the Children's Learning Center as much notice as possible.

Termination Procedures:
This contract may be terminated by the parent(s) or the provider upon two (2) weeks' written notice. Failure to provide proper notice will forfeit any tuition refund. *Catholic Charities Children's Learning Center may immediately terminate this contract without any notice if payment is not made on time. This contract may be revised by Catholic Charities Children's Learning Center at any time.*

By signing below you are in agreement with the contract and with the policies. Director has the right to change policies at any time without advance notice. A new contract will only be made when there is a change to attendance status or tuition amount which would change the payment agreement.

Signature:

Parent's Signature: ______________________________ **Date:** ______________________

CLC Representative Signature:___________________________ **Date:**_________________
______

Thank You!

For Office Use only

Date withdrawn:______________________ Reason for leaving:_____________________________________

Representative Signature:___________________________

REQUEST FOR ADMINISTRATION OF MEDICATIONS

NAME OF CHILD:________________________________DATE OF BIRTH:______________

TYPE OF MEDICATION: ☐ PRESCRIPTION ☐ NON PRESCRIPTION
NAME OF MEDICATION:____

DOSAGE TO BE ADMINISTERED:____

MEDICATION EXPIRATION DATE:_______________________________________

MEDICATION IS TO BE ADMINISTERED: 1.________________2.__________ 3.__________

TIME OF LAST DOSAGE GIVEN:____

DATES MEDICATION IS TO BE ADMINISTERES: BEGIN_________________END _______

IS CHILD TAKING ANY OTHER MEDICATION AT THIS TIME? ☐ YES ☐ NO
IF YES, NAME MEDICATION (S):_______________________________________

I REQUEST THE STAFF OF ______________________________ ADMINISTER THE ABOVE MEDICATION ACCORDING THE PRESCRIBED INFORMATION.

MEDICATION LOG

CHILDS NAME:

NAME OF MEDICATION	DOSAGE GIVEN	DATE	TIME	ADMINISTERED BY	TYPE OF REACTION	PARENT INITIALS

______________________________ ____________________
Parent Signature Date

______________________________ ____________________
Representative Signature Date

GUIDANCE POLICIES AND PROCEDURES AGREEMENT

I, ______________________________ have read and agree to follow the guidance policy and procedures.

____
Parent Signature

____
Date

____
Representative signature

____
Date

CATHOLIC CHARITIES CHILDRENS LEARNING CENTER HANDBOOK AGREEMENT FORM

I, ____________________________ HAVE READ AND AGREE TO SUPPORT AND COMPLY WITH THE POLICIES AND PROCEDURES CONTAINED WITHIN THE PARENT HANDBOOK.

CHILDS NAME:____

PARENT SIGNATURE:__________________________________

REPRESENTATIVE SIGNATURE:________________________

DATE:______________________________

Additional Family information (e.g. cultural background, religion, family traditions).

____
____
____
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____

FOOD ALLERGY AND SPECIAL DIET REQUEST

CHILDS NAME:_______________________________________
CLASSROOM:____DATE:______________

A REVIEW OF THE HEAD START HEALTH RECORDS INDICATE THAT YOUR CHILD IS ALLERGIC TO OR CAN NOT EAT THE FOLLOWING FOOD(S):

IN ORDER TO MODIFY THE MENU TO THE CHILD'S NEEDS, WE NEED A STATEMENT FROM YOUR DOCTOR, INDICATING THE PRESCRIBED DIET AND THE FOODS TO BE SUBSTITUTED. IF YOUR REQUEST IS MADE FOR RELIGIOUS REASONS, PLEASE WRITE A BREIF NOTE. ALL STATEMENTS SHOULD BE GIVEN TO YOUR CHILDS TEACHER FOR INCLUSION IN THE CLASSROOM FILE.

_________________________________ _________________________________

PARENT SIGNATURE **REPRESENTATIVE SIGNATURE**

CATHOLIC CHARITIES

NOTICE OF CLIENT RIGHTS AND RESPONSIBILITIES AND CONSENT TO SERVICES

As a client of Catholic Charities, you have certain rights and responsibilities regardless of the type of service you receive.

Client's Rights

1. The right to receive available services regardless of race, color, national origin, religion, sex, age, sexual orientation, marital status or political belief.

2. The right to have all services provided confidentially.

3. The right not to be deprived of any rights or privileges guaranteed by law.

4. The right to be informed of fees for service prior to receiving services and to be informed of eligibility requirements and hours of service for any services being sought.

5. The right to have services provided by qualified staff, and when possible, in the client's native language or through language translation.

6. The right to be free from any form of emotional, physical, or sexual abuse or neglect by the agency.

7. The right to be informed of the client complaint procedure, which is available to any client upon request. The right to make a complaint without fear of reprisal or of denied service based on the making of such complaint.

8. The right to have an individualized service plan and to participate in its development and any modifications.

9. The right to be informed of your responsibilities as a participant in an agency program and the conditions under which the agency may discontinue services.

10. The right to discontinue services at any time.

Client's Responsibilities

1. To maintain behavior/conduct that assures the safety, comfort, and well-being of all persons.

2. To give accurate information.

3. To pay all contracted fees, and to inform the agency within the required time period when canceling a scheduled service.

4. To cooperate with the service plan once accepted and as modified, if applicable.

5. To respect the right of the Agency to discontinue service if you fail to follow your service plan.

Notice of Confidentiality

We strive to maintain the confidentiality of your personal information but there may be instances which require us to disclose some of the information. Catholic Charities may use or disclose your personal information without your consent or authorization in the following circumstances:

1. *Required by Law* – Disclosures required by law including statute, regulation, or court orders.

2. *Public Health Activities* – Disclosures to:

   (1) public health authorities authorized by law to collect or receive such information for preventing or controlling disease, injury, or disability and to public health or other government authorities authorized to receive reports of child abuse and neglect;
   (2) entities subject to FDA regulation regarding FDA regulated products or activities for purposes such as adverse event or tracking of products
   (3) individuals who may have contracted or been exposed to a communicable disease when notification is authorized by law;
   (4) employers, regarding employees, when requested by employers, for information concerning a work-related illness or injury or workplace related medical surveillance, or needed to comply with state law

3. *Victims of Abuse, Neglect or Domestic Violence* – Disclosure may be made to appropriate government authorities regarding victims of abuse, neglect, or domestic violence.

4. *Health Oversight Activities* – Disclosure to health oversight agencies for legally authorized health oversight activities, including audits and investigations necessary for oversight of the health care system and government benefit programs.

5. *Judicial and Administrative Proceedings* – Disclosure made pursuant to an order from a court or administrative tribunal. Disclosure may also be pursuant to a subpoena or other lawful process if notice to the individual or a protective order is provided.

6. *Law Enforcement Purposes* – Disclosure to law enforcement officials for law enforcement purposes if:

   (1) as required by law (including court orders, court-ordered warrants, subpoenas) and administrative requests;
   (2) to identify or locate a suspect, fugitive, material witness, or missing person;
   (3) in response to a law enforcement official's request for information about a victim or suspected victim of a crime;
   (4) to alert law enforcement of a person's death, if the covered entity suspects that criminal activity caused the death;
   (5) when a covered entity believes that protected health information is evidence of a crime that occurred on its premises;
   (6) by a covered health care provider in a medical emergency not occurring on its premises, when necessary to inform law enforcement about the commission and nature of a crime, the location of the crime or crime victims, and the perpetrator of the crime.

7. Decedents – For reasons such as identifying a deceased person or determining the cause of death,

8. Cadaveric Organ, Eye, or Tissue Donation – Disclosure may be made to facilitate the donation and transplantation of cadaveric organs, eyes, and tissue.

9. Research – Disclosure may be made for research purposes. Research is defined under the Privacy Rule as "any systematic investigation designed to develop or contribute to generalizable knowledge" and disclosures are allowed in these instances:

(1) documentation that an alteration or waiver of individuals' authorization for the use or disclosure of protected health information about them for research purposes has been approved by an Institutional Review Board or Privacy Board;
(2) representations from the researcher that the use or disclosure of the protected health information is solely to prepare a research protocol or for similar purpose preparatory to research, that the researcher will not remove any protected health information from the covered entity, and that protected health information for which access is sought is necessary for the research;
(3) representations from the researcher that the use or disclosure sought is solely for research on the protected health information of decedents, that the protected health information sought is necessary for the research, and, at the request of the covered entity, documentation of the death of the individuals about whom information is sought.

10. Serious Threat to Health or Safety – Disclosures are permitted if they are believed to prevent or lessen a serious and imminent threat to a person or the public, when such disclosure is made to someone they believe can prevent or lessen the threat (including the target of the threat).

11. Essential Government Functions – Disclosure can be made in furtherance of essential government functions. These functions include: assuring proper execution of a military mission or conducting intelligence and national security activities that are authorized by law.

12. Workers' Compensation – Disclosure may be made as authorized by, and to comply with, worker' compensation laws and other similar programs providing benefits for work-related injuries and illnesses.

Uses and Disclosures With Your Authorization

For any other use of your personal information, Catholic Charities will obtain an authorization from you; that is, written permission specific to the situation. You may revoke such an authorization at any time, provided the revocation is in writing.

GRIEVANCES

With regards to any of the services received from Catholic Charities, you have a right to file a grievance at any time without fear of reprisal or loss of services as a result of such complaint. You may submit this grievance verbally, in person, by telephone or via email. A form was provided to you when you completed your Intake. You may use this form to submit your grievance. Our Chief Program Officer or Chief Executive Officer will address all grievances.

Catholic Charities Client Grievance Form

Grievances may be filed using this form or in other formats, including grievances submitted verbally, in person, by telephone, or via email

Client name________________________________ Date_________________

Date of event_______________________________

Description of event, including persons involved, witness (if any) and any attempts to resolve the problem. Use additional sheets if necessary.

Any retaliation against any Catholic Charites employee/client/board member/volunteer who exercise their right to file a grievance is strictly prohibited by state code and federal law.

______________________________________ _______________
Client signature Date

______________________________________ _______________
Received By Date

CATHOLIC CHARITIES CONSENT TO SERVICES

I am voluntarily seeking services at Catholic Charities for myself and/or my child(ren), and I give my consent for the staff of Catholic Charities to provide these services.

I understand that services will be provided confidentially within the limits noted in the rights and responsibilities policy and notice of confidentiality provided to me.

I understand that termination is usually an agreement between myself and the Catholic Charities staff member with whom I am working. However, I have the freedom to discontinue services at any time.

I understand that where there are charges for services, those charges are payable at the time service is provided.

I have read the Notice of Client Rights and Responsibilities and the Notice of Confidentiality.

I have read, understood, and received a copy of Catholic Charities' Grievance Form.

____

Client name *(please print)*

____

Client signature *(Parent/guardian of client must sign if a client is a minor)* **Date**

____

Client name *(please print)*

____

Client signature *(Parent/guardian of client must sign if a client is a minor)* **Date**

This document was interpreted into the ________________language by ____________________________.
(name of language) (print name of interpreter)

_______________________________ ________________

Interpreter signature date

Revised 10/2019.

New Child Checklist

- ☐ Enrollment packet
- ☐ Food program forms
- ☐ Review family handbook / Policies
- ☐ Review classroom assignment
- ☐ Meet the teachers
- ☐ Turned in shot record
- ☐ Turned in CYFD contract if applicable
- ☐ $50 registration fee paid
- ☐ First months tuition paid
- ☐ Extra clothes
- ☐ Diapers if applicable
- ☐ Wipes if applicable
- ☐ Bottle if applicable
- ☐ Dr’s note if applicable

If anything listed above was not turned in at the time of enrollment please list the date it will be turned in: ____

____

____

____

____

Classroom:_________________ Phone Number:_____________________________

Teacher:____