



Squaxin Island Child Development Center Enrollment Packet

**Welcome to
Squaxin Island Child Development Center!**

Welcome to the Squaxin Island Child Development Center. We are glad to have you and your child(ren) with us! The staff at SICDC is looking forward to serving you and your family. Our goal is to build a positive, long-lasting relationship with you and your most important people – YOUR CHILD(REN)!

Enclosed in this enrollment packet are all the necessary forms for enrollment, as well as, important informational fact sheets to help you understand our forms used in the classroom.

Child's Enrollment Packet includes the following;

- Enrollment Application
 - Please be sure to fill this out completely so that we can provide you with the best possible service for you and your child
 - Both addresses and phone numbers are essential in case of an emergency
 - Don't forget – Health & Personal Information
- Emergency Medical Care Consent Form
 - This gives us the authority to follow our emergency procedures if necessary
- Illness & Medication Forms Policies
 - This is information for your files. There are certain procedures we must follow for dispensing medicine, as well as, certain illnesses where children must stay at home
- State Forms
 - Mandatory forms required by the State of Washington (i.e. Immunization Form, Free/Reduced Meal Application)
- Other Miscellaneous Forms
 - Photo & Video release form, so we can include your child in center publications, newsletters, and press releases.
 - Field Trip Permission Form
 - Early Achievers Permission Form
 - Ages & Stages Survey Permission Form
 - Permission and Acknowledgement of Assessments and Conferences

Additional information you will receive from the Center Director

- Tour of Facility
- Tuition Schedule & Rate Sheet
- Tuition Agreement
- Parent Handbook
- Current Newsletter
- What do I need to bring on my first day!

EHS Enrollment Application

Return to: SICDC

1. Basic Information about child

Program you are applying for: EHS ECEAP Outdoor Child Care School year applying for: _____

Legal First Name _____ Middle Name _____ Legal Last Name _____

Child's birth date ____/____/____ Nickname _____ Gender _____

Squaxin Tribal Member: Yes No

Tribal Enrollment # _____

Other Tribal: Yes No

Tribal Enrollment # _____

Tribal Employee: Yes No Entity: _____ Full Time Part Time

2. Family Contact Information

Do you need an interpreter to communicate with English speakers? Yes No

If yes, what language(s) do you speak? _____

Physical Street Address _____ Apt # _____ City _____ Zip _____

Mailing Address (if different) _____ City _____ Zip _____

Guardian's Name: _____ Employer: _____

Work Phone: (____) ____ - ____ Cell Phone: (____) ____ - ____ Cell Phone Carrier: _____

E-Mail: _____ Contact Preference: Phone E-mail

Guardian's Name: _____ Employer: _____

Work Phone: (____) ____ - ____ Cell Phone: (____) ____ - ____ Cell Phone Carrier: _____

E-Mail: _____ Contact Preference: Phone E-mail

3. Emergency Information for Squaxin Island Child Development Center

Date: _____ EHS ECEAP Outdoor Child Care

Child's Name: _____ Birthdate: _____

Transportation: BUS (if applicable) Car Walk

Parent/Legal Guardian 1: _____

Parent/Legal Guardian 2: _____

Street Address _____ City _____ Zip Code _____

Mailing Address _____ City _____ Zip Code _____

Parent 1: _____ Parent 2: _____

Cell Phone _____ Cell Phone: _____

Work/Home _____ Work/Home: _____

Email: _____ Email: _____

Best time to reach you? _____ Best time to reach you? _____

Emergency Medical Information for Enrolled Child

Allergies: _____

Medical Concerns: _____

Medications: _____

Medical Conditions, if any: _____

Emergency contacts (other than yourself)

List name and phone number of people who can pick up or receive your child in the event of an emergency.

1: Name _____ Phone number _____

2: Name _____ Phone number _____

3: Name _____ Phone number _____

Biological parent (if not already listed) _____

Does the biological parent have permission to pick up this child? YES NO

If no, why? _____

Current custody agreement on file? YES NO DATE: _____

Limitations or restrictions for picking up child? _____

Describe: _____

Current restraining order? YES NO DATE: _____

Child Health Care Provider: _____

Phone number: _____ Address: _____

Child's Dentist: _____

Phone number: _____ Address: _____

Affiliated hospital: _____ Last Tetanus Immunization: _____

Is your child up to date on all immunizations for their age at this time? YES NO

For your child's safety, your signature below grants Squaxin Island Child Development staff permission to provide your child with emergency treatment including First aid and CPR. When deemed immediately necessary, medical, surgical, hospital care, treatment and procedures will be provided by your child's regular health care provider, or by a licensed physician, or hospital if your regular health care provider cannot be reached. If you cannot be reached, transportation will be provided by ambulance or by any of the people named above to an emergency center for treatment.

Parent/Guardian Signature

Date: _____

Print Name

4. Authorized pick up

If I/We cannot pick-up or child(ren), I hereby authorize the following person(s) to pick-up my child(ren).

Name: _____ Relation: _____

Phone Number: (____) ____ - _____

Name: _____ Relation: _____

Phone Number: (____) ____ - _____

Name: _____ Relation: _____

Phone Number: (____) ____ - _____

Name: _____ Relation: _____

Phone Number: (____) ____ - _____

5. Child lives with:

One parent/guardian (Name) _____ **Skip to section 6.**

Two parents/guardians in same household (Names) _____
_____ **Skip to section 6.**

Two parents/guardians in two households
If this is checked, answer these questions to determine which parents' income is counted for EHS/ECEAP eligibility.

Does one household have primary legal custody? Yes No

If **yes**, which parent has primary custody? _____
Spouse of this parent, if any: _____ **Skip to section 6.**

If **no**, does one parent receive child support payments from the other household? Yes No

If **yes**, which parent receives the child support payments? _____
Spouse of this parent, if any: _____ **Skip to section 6.**

If **no**, EHS will count the income from the legal parent/guardian for each household. Do not include their spouses. Enter the legal parents' names here:

Household 1 _____ Household 2 _____

Contact Info for Household 2:

Physical Street Address _____ Apt # ____ City _____ Zip _____

Mailing Address (if different) _____ City _____ Zip _____

Email _____

Phone _____ Alternate Phone _____

6. Child Information

IEP/IFSP - Is this child on an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP)?

Yes No

If no, do you have any concerns about this child's development?

Yes No

CPS/ICW - Is this child's family currently receiving Child Protective Services (CPS), Family Assessment Response (FAR), or similar Indian Child Welfare (ICW) services?

Yes No

Foster Care - Is this child in official foster care? *This means there is a caregiver authorization from a state or tribe that says this is a foster care placement.*

Yes No

Kinship - Is this child in kinship care – with or without a grant, with a relative or suitable other?

Yes No

Adopted after foster/kinship care - Was this child adopted after foster or kinship care?

Yes No

If this child does not reside with biological parents we will need supporting documentation.

Housing (select one):

- Rent or own an adequate residence
- Doubled-up with another family for convenience, choosing to be close to family or friends, or choosing to save money for future plans
- Doubled-up with another family due to loss of housing, economic hardship or a similar reason
- In an emergency or transitional shelter
- Sleeping in a hotel, motel, car, park, campsite or similar location
- Moving from place to place (couch surfing)
- Inadequate housing such as no water, heat or electricity; excessive mold; or no cooking facilities

Language This child speaks (select only one):

- Only English
- Mostly English, and some of another home language
- Some English, but mostly another home language
- English and another language at age level (bilingual)
- Only a home language other than English

Child's first language _____ Child's second language _____

Is this child Hispanic/Latino? Yes No

If yes, check all that apply:

- | | | |
|--|--|---|
| <input type="checkbox"/> Argentinian | <input type="checkbox"/> Guatemalan | <input type="checkbox"/> Salvadoran |
| <input type="checkbox"/> Bolivian | <input type="checkbox"/> Honduran | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Chilean | <input type="checkbox"/> Mexican or Mexican-American (Chicano) | <input type="checkbox"/> Uruguayan |
| <input type="checkbox"/> Colombian | <input type="checkbox"/> Nicaraguan | <input type="checkbox"/> Venezuelan |
| <input type="checkbox"/> Costa Rican | <input type="checkbox"/> Panamanian | <input type="checkbox"/> Latin American |
| <input type="checkbox"/> Cuban | <input type="checkbox"/> Peruvian | <input type="checkbox"/> Other Hispanic or Latino |
| <input type="checkbox"/> Dominican | <input type="checkbox"/> Puerto Rican | (describe) _____ |
| <input type="checkbox"/> Ecuatorian (Ecuadorian) | | |

13. Previous Enrollment

This child was previously enrolled in

- | | |
|--|---|
| <input type="checkbox"/> Head Start at your agency | <input type="checkbox"/> Early Head Start |
| <input type="checkbox"/> Head start with a different agency | <input type="checkbox"/> Any birth-to-three home visiting program |
| <input type="checkbox"/> Migrant/Seasonal Head Start
Anywhere in Washington | <input type="checkbox"/> ESIT - Early Support for Infants and Toddler |

14. IEP/IFSP or Suspected Delay

- This child has an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP).
- This child has a suspected developmental delay or disability.

If this child has an IEP/IFSP check all categories of the IEP/IFSP.

- | | | |
|--|--|--|
| <input type="checkbox"/> Autism | <input type="checkbox"/> Intellectual disability | <input type="checkbox"/> Specific learning disability |
| <input type="checkbox"/> Deaf blindness | <input type="checkbox"/> Multiple disabilities | <input type="checkbox"/> Speech or language impairment |
| <input type="checkbox"/> Developmental delay | <input type="checkbox"/> Orthopedic impairment | <input type="checkbox"/> Traumatic brain injury |
| <input type="checkbox"/> Emotional disturbance | <input type="checkbox"/> Other health impairment | <input type="checkbox"/> Visual impairment |
| <input type="checkbox"/> Hearing impairment | | |

IEP/IFSP Start Date _____ IEP/IFSP End Date _____

What school district issued this child's IEP/IFSP? _____

Is a school district special education preschool available for this child? Yes No

If your child does not have an IEP/IFSP, do you suspect that your child has a developmental delay or disability? Yes No

If yes, please describe: _____

15. Has this child been asked to leave a childcare or preschool because of behavior challenges? Yes No

EHS/ECEAP/SICDC serves children with behavior challenges. Checking yes will not exclude your child.

16. Additional Questions

We use this information to choose the children who most need **EHS/ECEAP**. All responses will be kept confidential.

- Has this child been homeless within the last 12 months? Yes No
- Has this child been reunited with parents after foster or kinship care in the past 12 months? Yes No
- Does this child have a parent who is developmentally or physically disabled? Yes No
- Does this child have a parent currently on active duty in the U.S. Military? Yes No
- Does this child have a parent currently a member of a National Guard unit or a Military Reserve unit? Yes No
- Does this child have a military parent deployed currently, or within the past 12 months, or for a total of 19 or more months within the child's lifetime? Yes No
- Does this child have a parent who is incarcerated in jail, prison or a detention center? Yes No
- Does this child have a household family member who has a chronic physical or mental health condition that:
- Severely impacts their ability to engage in work, school, or family life? Yes No
- Moderately impacts their ability to engage in work, school, or family life? Yes No
- Has this child experienced the divorce or separation of their parents? Yes No
- Does this child have a parent who was under age 18 when this child was born? Yes No
- Does this child have a parent who is a migrant worker? Yes No
- Has this family received CPS/FAR/ICW services or involved with law enforcement/court system involvement regarding child abuse, neglect or sexual assault in the past? Yes No
- Has this child's lived in a household with domestic violence, including in-utero? Yes No
- Has this child experienced the loss of a parent, such as by death, abandonment, or deportation? Yes No
- Does this child's lived in a household with substance abuse, including in-utero? Yes No
- EHS/ECEAP** received a professional referral for this family. Yes No

If yes, which agency made the referral? _____

17. Health Information *Please attach a copy of the child's immunization record*

Does this child have a chronic health condition such as diabetes, asthma, seizures, etc.? Yes No

If yes, please describe _____

Does this child have any allergies to any of the following? Food, Drug Reactions, Other? _____

Special Instructions: _____

Is your child under a doctor's care for any condition? Yes No

If yes, please explain: _____

Did this child weigh less than 5.5 pounds when they were born? Yes No Unknown

Does this child have medical insurance or coverage? Yes No Unknown

- Washington Apple Health for Kids/ Provider One Services Card
- Military Coverage Private Medical Insurance
- Tribal Coverage

Does this child have a regular doctor or medical clinic? Yes No Unknown

Name of clinic or provider _____

Phone (optional) _____

Name of medical professional _____

Did this child have a well-child exam within the last 12 months? Yes No Unknown

Date of last well-child exam before applying for our program ____/____/____ Date Unknown

Does this child have dental insurance or coverage? Yes No Unknown

- Washington Apple Health for Kids/ Provider One Services Card
- Military Dental Coverage Private Dental Insurance
- ABCD (not available in all counties) Tribal Coverage

Does this child have a regular dentist or dental clinic? Yes No Unknown

Name of clinic or provider _____

Phone (optional) _____

Name of dental professional _____

Did this child have a dental screening within the last 6 months? Yes No Unknown

Date of last dental screening before applying for our program ____/____/____ Date Unknown

Note: If child is under a physician's care an INDIVIDUAL HEALTH PLAN must accompany enrollment packet? See Center Management for more information.

This section to be completed only if your child does not have any special needs or health conditions that need to be cared for at the Center. ***My child has no special needs or health conditions that require treatment during his/her time at the Squaxin Island Child Development Center.***

Signature _____ **Date** _____

Tell Us About Your Child

What does your child like to be called: _____

Is your child responsible for their own toileting? YES NO

Has your child been enrolled in an early learning program before? YES NO

If yes, where: _____

What are some of your child's favorite activities?

What does the family enjoy doing together?

In what areas of development are you working on at home with your child? How can we support you?

What are some ways we can support your child when they are frustrated, angry, or sad?

How does your child display emotions?

How would you prefer the Teachers to reach you?

What are some learning goals would you like us to work on with your child?

What brings your child comfort in a new social setting?

What are your childcare concerns?

Other information you would like to share with us about your child:

Squaxin Island Child Development Center Permission Form

Child Name: First / Last

Date of Birth

Please Circle yes or no to the following questions

Transportation and off-site activity

I give permission for the licensee to take my child:

On a walk around the property "Beyond the Fence" Yes / No

On a field trip (with at least 24 hours written notice) on the bus/transportation..... Yes / No

Comments:

Water Activities

I give permission to take my child swimming:

At the local indoor pool with a lifeguard..... Yes / No

Comments:

Photo, video, surveillance

I give permission for the center to:

Take photographs and video of my child to share with you..... Yes / No

To post my child's photo on Facebook and in Media outlets..... Yes / No

To capture my child's image on surveillance through our security system Yes / No

Comments:

Sunscreen:

I give permission for the center to apply sunscreen to my child:

Using center provided sunscreen called "**Banana Boat SPF50+**" with active ingredients: **Titanium**

Dioxide 4.5% and Zinc Oxide 6.5% as according to manufactures directions Yes / No

Comments:

Tooth-brushing:

I give permission for my child to brush their teeth at the center:

To Brush using water only..... Yes / No

To Brush using child appropriate/Fluoride toothpaste provided by the center

(Children age 2+ only) Yes / No

Comment:

COVID Test to Stay:

I give permission for my child to be COVID tested here at the center after an exposure or due to symptoms.

Testing negative will allow your child to stay at school Yes / No

Comment:

I have reviewed the SICDC's written policies and have had the opportunity to discuss these policies as they pertain to my child.

Parent/guardian signature:

Date:

Emergency contact # _____

Child Care Agreement

Child's Name: _____

My child will be attending the center on the following days and times listed below:

	Monday	Tuesday	Wednesday	Thursday	Friday
Arrival Time					
Departure Time					

* **Required attendance for EHS: 9:00AM to 3:00PM Monday through Friday ECEAP: 8:00 AM to 12:00 PM Monday through Friday**

Enrollment Fee \$ _____
Tuition Fee \$ _____
Date Due 1st of each month

Contract Agreement

- _____ I agree to comply with the Policies and Procedures of the Squaxin Island Child Development Center
- _____ I understand that the tuition payments are due in advance of the services rendered. My payments are due by the 1st of each month for the coming month, and if my _____ account is not paid in full by the 5th of each month a \$35 late payment fee will be charged. If I become overdue in my payment by more than three (3) days, my child(ren) will not be permitted to attend the center until my account is completely up to date.
- _____ Rates are based on yearly expenses, and do not change for sick or holiday absences.
- _____ I will pay a \$35 fee for returned checks plus any bank fees.
- _____ I agree to promptly notify the Center Director in writing of any changes to the above mentioned schedule, so a new contract can be made. A two (2) week notice is necessary for withdrawal.

For Subsidized Child Care Only

- _____ I will provide verification of subsidy approval
- _____ I am financially responsible for co-payments due on the 1st of each month
- _____ State requirement for co-payment, schedule calendar, pay stub copy, and/or childcare hours must be turned in by the 5th of each month
- _____ If my child misses more than five (5) days in a month, SICDC reserves the right to discontinue child care services
- _____ I am responsible for childcare payments when assistance has been terminated

Name of Caseworker _____ Phone # (____) _____-

Parent Signature _____ **Date** _____

Parental Acknowledgement of Receipt and Understanding of Handbook

_____ I/We acknowledge I/We have received and read the SICDC Parent Handbook.

_____ I/We understand and agree that it is my/our responsibility to familiarize myself/ourselves with the Policies & Procedures of the SICDC.

_____ In addition, I/We understand that this handbook reflects SICDC Policies, as well as, Policies of the Squaxin Island Tribe, State of Washington, EHS, and ECEAP.

_____ I/We acknowledge that I/We have read and understand all Policies & Procedures of the SICDC and the programs we have signed our child up for.

_____ I/We understand that if I/We have any questions or concerns with any stated Policies & Procedures of this handbook, I/We will speak with the Center Director to clarify any or all questions or concerns.

_____ I/We understand that information in this handbook is subject to change.

_____ I/We understand that failure to notify the center of non-attendance for more than 30 days will result in de-activation of services. To re-enroll a new application packet must be completed and you may be placed on a waiting list.

Signature of Parent

Date

Signature of Staff

Date

A copy of this signed document must be kept in your child's files.

Squaxin Island Child Development Center
Program Agreement Form

Child's Name: _____

I give permission for my child to:

1. YES NO Have routine screenings (developmental, behavioral, and general mental health observations given as part of the programs offered at the center.
2. YES NO Have routine health screenings (vision, hearing and growth assessment).

I agree that:

3. YES NO I agree that personal cell phone/camera/ text use is prohibited in the classroom and during scheduled center activities, except for emergencies.
4. YES NO My child will receive immunizations as required by state law.
5. YES NO My child will have physical and dental examinations.
6. YES NO My child will have regular classroom attendance (85%) or attend agreed upon center activities. I will call the center if my child will be absent or late. I will arrive to pick my child up on time.
7. YES NO Center staff may make home visits/Conference at my convenience. It is my responsibility to keep scheduled appointments.
8. YES NO I understand I will be provided access to the Center Disaster Plan and pesticide use information by center staff.
9. YES NO Center policies and procedures, philosophy and facilities have been shared with me.
10. YES NO The center may send me emails or texts.
11. YES NO My child and I may receive mental health consultation services.

I give permission for SICDC enrollment staff to contact the following people to obtain the needed information to finalize enrollment.

1. YES NO SIT Housing Occupancy Specialist for family size verification.
2. YES NO SIT Family services for ICW and TANF verification.
3. YES NO Enrollment Officer for Squaxin Tribal Membership verification.

Signature of Parent /Guardian: _____ Date: _____

Squaxin Island Child Development Center Tuition Rate Sheet Effective June, 2025

Category	Full Time <u>4 or more days or 100 hours or more per month</u>	Part Time <u>3 or less days or less than 100 hours per month</u>
Infant 1 -12 months	\$1,450 \$1,440 (Electronic Funds Transfer)	\$1160 \$1150(Electronic Funds Transfer)
Toddler 12-36 months	\$1,300 \$1290(Electronic Funds Transfer)	\$1,040 \$1,030 (Electronic Funds Transfer)
Preschool 3 years – start kindergarten	\$1,200 \$1,190 (Electronic Funds Transfer)	\$960 \$950 (Electronic Funds Transfer)

Additional Non-Refundable Fees –

- **Annual Registration Fee: (Billed every September)**
 - Family - \$150.00
 - Child - \$100.00
- **Late Pick-up Fee: After 6:00pm (CASH ONLY)**
 - \$35 late fee plus \$1.00 per minute/per child
- **Multi-child Discount:**
 - 10% discount for the eldest child enrolled.
- **Return Check Fee:**
 - \$35 per check-plus any bank fees assigned to the Center
- **Field Trip/Special Activity**
 - As needed basis