Squaxin Island Child Development Center Enrollment Packet

Revised September 2023

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 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

<u>Additional information you will receive from the Center Director</u>

- 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.

____ Date: _________________
Parent/Guardian Signature

____
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:

- ☐ Argentinian
- ☐ Bolivian
- ☐ Chilean
- ☐ Colombian
- ☐ Costa Rican
- ☐ Cuban
- ☐ Dominican
- ☐ Ecuatorian (Ecuadorian)
- ☐ Guatemalan
- ☐ Honduran
- ☐ Mexican or Mexican-American (Chicano)
- ☐ Nicaraguan
- ☐ Panamanian
- ☐ Peruvian
- ☐ Puerto Rican
- ☐ Salvadoran
- ☐ Spanish
- ☐ Uruguayan
- ☐ Venezuelan
- ☐ Latin American
- ☐ Other Hispanic or Latino (describe)____________________

13. Previous Enrollment

This child was previously enrolled in

- ☐ Head Start at your agency
- ☐ Head start with a different agency
- ☐ Migrant/Seasonal Head Start
  Anywhere in Washington
- ☐ Early Head Start
- ☐ Any birth-to-three home visiting program
- ☐ ESIT - Early Support for Infants and Toddle

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.

- ☐ Autism
- ☐ Deaf-blindness
- ☐ Developmental delay
- ☐ Emotional disturbance
- ☐ Hearing impairment
- ☐ Intellectual disability
- ☐ Multiple disabilities
- ☐ Orthopedic impairment
- ☐ Other health impairment
- ☐ Specific learning disability
- ☐ Speech or language impairment
- ☐ Traumatic brain injury
- ☐ Visual 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 child care 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.***

***Signiture*____*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: 8:00am to 2pm M-F ECEAP: 8:00am to 12:00pm M-F (if applicable 12:00pm to 4:00pm M-F)**

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 January 1, 2017

Category	Full Time 4 or more days or 100 hours or more per month	Part Time 3 or less days or less than 100 hours per month	Drop-In Daily *(if space is available)*
Infant **1 -12 months**	$1,000/$990 (EFT)	$815/$805	$70
Toddler **12-36 months**	$905$895 (EFT)	$720/$710	$70
Preschool **3 years – start kindergarten**	$855/$845 (EFT)	$685/$685	$70

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**