BELLEVUE
COMMUNITY CENTER

2015-2016
Early Childhood Education
&
Before and After School K-5

REGISTRATION PACKET

510 Duncan Rd., Wilmington, DE 19809, Phone: 302-762-1391

WELCOME!

Weekly Childcare Fees:

CLASS	AGES	5 FULL DAYS	3 FULL DAYS	5 HALF DAYS
TEDDY BEARS	1-2yr	$230.00	$165.00	$140.00
KOALAS	2-2 ½yr	$187.00	$134.00	$114.00
LOVEBUGS	2 ½-3yr	$168.00	$120.00	$103.00
LOLLIPOPS	3-4yr	$168.00	$120.00	$103.00
FOREST FRIENDS	Pre-K	$168.00	$120.00	$103.00

Monthly School Age Fees:

CLASS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
BEFORE CARE ONLY	$130.00	$140.00	$150.00	$160.00
AFTER CARE ONLY	$145.00	$155.00	$165.00	$175.00
BOTH	$260.00	$270.00	$280.00	$290.00

School Age Income Scale:

FAMILY SIZE	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
2 Person	Up to $25,498	$29,140	$36,425	$43,710
3 Person	$32,043	$36,620	$45,775	$54,930
4 Person	$38,588	$44,100	$55,125	$66,150
5 Person	$45,133	$51,580	$64,475	$77,370
6 Person Or More	$51,678	$59,060	$73,825	$88,590

~$10.00 Off Weekly or Monthly Fee For Each Additional Child~

Ex: Your child signs up for a $168.00/wk class. Your second child would be $158.00/wk for another class

A completed application must include for enrollment:

1. $25.00 non-refundable fee (POC- Free)
2. Every signature line required to be signed
3. Copy of State issued form of identification
4. Copy of current child physical form (NOT shots record)
5. Food Eligibility Form completed (regardless income)
6. Proof of income
    a. 2 consecutive pay stubs dated within the last month
    b. W-2 of 1040 tax form
    c. Form 6180 for POC

BCC Holiday Closures

Monday, September 7, 2015	Labor Day
Thursday, November 26, 2015	Thanksgiving
Thursday, December 24, 2015	Christmas Eve
Friday, December 25, 2015	Christmas
Thursday, December 31, 2015	New Year's Eve
Friday, January 1, 2016	New Year's Day
Monday, February 15, 2016	Staff In-Service (Closed)
Friday, March 25, 2016	Good Friday
Monday, May 30, 2016	Memorial Day
Friday, June 3, 2016	12:00 Closing for In-Service
Monday, July 4, 2016	Independence Day

Registration Form For Individual Child

REGITRATION FOR (check one): **CHILDCARE**_____ **SCHOOL-AGE**_____ **& SCHOOL GRADE**_____**(K-5)**

School Name: _____

CHILD'S NAME: _____ TO BE CALLED: _____

TODAY'S DATE: _____ CHILD'S BIRTHDATE: _____ AGE: _____ GENDER: _____

STREET ADDRESS: _____

CITY, STATE & ZIP: _____

HOME PHONE: _____ CHILD LIVES WITH: _____

4 DIGIT PIN CODE_____ LANGUAGE SPOKEN AT HOME: _____

PARENT/GUARDIAN: _____ RELATIONSHIP: _____ HM ADDRESS: _____ _____ HOME PHONE: _____ EMPLOYER: _____ WORK PHONE: _____ CELLPHONE: _____ E-MAIL: _____ Check: ❒Custodial Parent ❒ Non-custodial Parent ❒Joint Custody ❒Legal Guardian Approved for Pick-up: ❒Yes ❒No Court Order Provided: ❒Yes ❒No	PARENT/GUARDIAN: _____ RELATIONSHIP: _____ HM ADDRESS: _____ _____ HOME PHONE: _____ EMPLOYER: _____ WORK PHONE: _____ CELLPHONE: _____ E-MAIL: _____ Check: ❒Custodial Parent ❒Non-custodial Parent ❒Joint Custody ❒Legal Guardian Approved for Pick-up: ❒Yes ❒No Court Order Provided: ❒Yes ❒No

Other Household Members: (List Name, Age and Relationship to Child)

_____

_____

Child's Physician or Clinic: _____ Phone_____

Other Emergency Contacts & Persons Authorized to Pick-Up Child (other than parents/guardians):

NAME _____ RELATION TO CHILD: _____

ADDRESS _____ PHONE: (w)_____ (h)_____

NAME _____ RELATION TO CHILD: _____

ADDRESS _____ PHONE: (w)_____ (h)_____

NAME _____ RELATION TO CHILD: _____

ADDRESS _____ PHONE: (w)_____ (h)_____

NAME _____ RELATION TO CHILD: _____

ADDRESS _____ PHONE: (w)_____ (h)_____

- **Only Authorized Persons are allowed Pick-Up. In an event an un-authorized person must pick-up, the Parent/Guardian must present in writing authorization for that individual to pick-up with ID.**

Allergies/Food Allergies (require Doctor's note): _____

Medical conditions, Serious Accidents, Operations, Etc: _____

Medication Taken Regularly: _____

SCHOOL AGE ONLY: Before Care ___ After Care ___ Both ___ Payment Category ___

Extra Care Days, Attendance And Purchase of Care

Child's Name: _____ **Parent/Legal Guardian Name:** _____

As a parent/guardian of a child participating, I agree to follow the procedures and conditions in the Parent Handbook. I acknowledge and agree to the following conditions, responsibilities and information:

School Age Only:

- **The fee is due 2 weeks before your child attends each week or month.**
- There are fees for days indicated on any ***Extra Care Days forms*** ($30.00 per enrolled child, $40 for holiday only child). This is in addition to your monthly fee.
- Winter/Spring Break: $30 per day *extra* to what you pay per month
- School Closings (non-weather related): $30 per day *extra* to what you pay per month
- **After the due date**, the fee for the *Extra Care* will be $35 per enrolled child, $45 for holiday only.

Critical Information:

- There is a returned Check fee of $20.00. After 2 returned checks only cash payments will be accepted.
- I understand that space is reserved for my child according to the program schedule of planned attendance. I will submit the monthly fee regardless of holidays, closings due to inclement weather, or my child's absence for whatever reason. I will pay the fee in advance, one week prior to the first program day of the next month. **If the fee is not paid by the due date, I understand that my child will not be admitted to the program until payment is received in full or a payment plan is established.**
- I understand that the program closes at 6:00pm and a late fee will be charged if my child is picked up after that time. I realize late fees will be doubled, and services may be suspended for *continued* late pick-ups. Late fees are: $10 for 6:01-6:15, $15 additional for every 1-15 minutes after that. **If a child is NOT picked up by 7:00pm, the Division of Youth and Social Services will be called for abandonment.**
- I understand that if my child is suspended from school, the child may not attend after school program.
- If my child becomes ill at the BCC, they must take **1 FULL DAY** off the program before coming back even if they return to school.

Purchase of Care (POC) Participants Only:

As a parent/guardian of a child participating in the Bellevue Community Center School Age program, through a POC contract, I acknowledge and agree to the following conditions, responsibilities and information.

- It is my responsibility to maintain a current authorization for POC. If POC coverage expires, I will submit full payment for all childcare services received during the period for which POC was not authorized.
- I understand that because POC will pay for only 5 absences per month, should my child miss additional days during each month, he/she will be withdrawn from the program and/or I will be charged according to the standard fee schedule.
- If payments for "absent days" are not received by the next business day, my child will be suspended from the program.

Required Parent Signatures of All Releases

Child's Name: _____ **Parent/Legal Guardian Name:** _____

REPORTING INCIDENTS / ACCIDENTS AND PERMISSION FOR CARE
I hereby grant permission for BCC staff to use whatever steps may be necessary to obtain emergency medical for my child if necessary. I hereby, for services rendered, release the Bellevue Community Center, their respective employees, Partners, and Board of Directors, of any and all liabilities. Incidents will be reported of the day with parent.

Parent/Legal Guardian Signature: _____ **Date:** _____ / _____ / _____

PHOTO AND VIDEO RELEASE:
I hereby give my permission for my child's photo and/or video to be used for Bellevue Community Center publicity. They will also have access to technology under the supervision of staff.

Parent/Legal Guardian Signature: _____ **Date:** _____ / _____ / _____

USING BUSES FOR TRIPS, TRANSPORT RELEASE:
I hereby give my permission for my child to be transported via charter bus, district bus, or BCC bus for field trips, pickups and drop offs if applicable. Please list any special needs or problems which might require special attention during transportation and directions on how to handle them. The information will be carried with the operator of the vehicle. Also, for childcare, permission to leave via stroller or walks under staff supervision in surrounding neighborhoods.

Parent/Legal Guardian Signature: _____ **Date:** _____ / _____ / _____

RELEASE OF SCHOOL INFORMATION:
I give permission to provide continuity of care, the Bellevue Community Center staff will communicate with the school staff to obtain a copy of IEP's, Individualized Transition Plan, behavior reports, progress reports, achievement testing scores and Teacher/Counselor observations and ratings. Copy of school health records to complete the school age program medical files required by the state of Delaware's Office of Child Care & Licensing regulations.

Parent/Legal Guardian Signature: _____ **Date:** _____ / _____ / _____

COMPUTERS/ TV / DVD
Children, over the age of 2 years old, will have the opportunity to occasionally play educational games on the computer. Children will be closely supervised to ensure that age-appropriate and educational websites are being viewed while using the internet. Computer time will not exceed one hour in length.

Parent/Legal Guardian Signature: _____ **Date:** _____ / _____ / _____

RECEIPT OF PARENT INFORMATION
I certify that I have received information regarding the following topics: a typical day schedule, positive behavior management techniques, routine and emergency care, health exclusions, and preventions of communicable diseases, food and nutrition, procedures for releasing children, reporting accidents, injuries in critical incidents, mandating reporting of child abuse and neglect, administration of medication procedures, safe sleep procedures for infants (not applicable), pets or animals present in the home regardless of the location within the Family Child Care Home (not applicable) and transportation, if provided.

Parent/Legal Guardian Signature: _____ **Date:** _____ / _____ / _____

Information About My Child For Their Teacher

Child's Name: _____ **Age:**_____ **Grade (if applicable):** _____

Please help the Bellevue Community Center introduce your child to their new after school teachers. This helps the teacher to get-to-know your child as they enter the program, build a rapport of interest, and establish a line of communication with the family.

What does your child enjoy doing most? _____ **and/or**

- Sports, outside, run around
- Draw, build, games
- Read, write, homework time

As a parent, what type of behavior re-direction have you found most effective?

_____

_____

What toys, hobbies, craft, music skills, collections and other leisure activities does your child enjoy?

_____

_____

How would you describe your child's personality?

_____

What things does your child need to work on? _____

_____

Does your child have any fears? _____

In what ways would you like to be involved in your child's program?

Parent Council _____ Tutoring _____ Teacher Helper _____

(Childcare Only) Is your child toilet trained?

- **Yes**
- **No**
- **Working On**
- **Occasional Accidents**
- **Needs Reminding**

Thank You! Let's Have A Great Year!

Federal Food Service Program And Health Appraisal

FOOD SERVICE

BCC administers the Child and Adult Care Food Program. A breakfast, lunch, and afternoon snack are served daily to the participants of the childcare and school age programs. Summer camp, however, serves only lunch and a snack. The goal of the childcare center meal service is not just to fill children's stomachs today, but rather, to meet the child's nutritional needs while creating positive eating habits that will last a lifetime.

Menus are designed to meet both the CACFP meal pattern requirements and licensing requirements. Menu planning takes differences in texture, color, tastes, and temperature into consideration. All food items on the menu for each meal are prepared in quantity to satisfy the minimum serving size for each child as required by CACFP. We ensure that all adults and children follow food safety practices by washing their hands and wearing gloves before food preparation and/or set-up before meal service and washing hands after clean-up.

CHILD AND ADULT CARE FOOD PROGRAM POLICY - CACFP

In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, and disability. (Not all categories of consideration apply to all programs.) To file a discrimination complaint, write to USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue SE, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

SUMMER FOOD SERVICE PROGRAM – SFSP

The Summer Food Program is a federal program of the Food and Nutrition Services, United States Department of Agriculture. The program provides all children 18 years of age and under with the same free meal in accordance with a menu approved by the state agency regardless of race, color, national origin, sex, age or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

CHILD HEALTH APPRAISAL

Before Registration is complete, each child must have a current (within 1 year) health appraisal completed by their physician turned in with the registration. This secures the safety and health of each child enrolled in all programs and follows State licensing regulations.

YOU MUST FILL OUT THE *FOOD SERVICE ELIGIBILITY FORM* AND *HEALTH APPRAISAL* BEFORE REGISTERING. THANK YOU.

Women, Infants, And Children (WIC)

About WIC- WIC at a Glance

Population Served:

The WIC target population are low-income, nutritionally at risk:

- Pregnant women (through pregnancy and up to 6 weeks after birth or after pregnancy ends).
- Breastfeeding women (up to infant's 1st birthday)
- Non-breastfeeding postpartum women (up to 6 months after the birth of an infant or after pregnancy ends)
- Infants (up to 1st birthday). WIC serves 53 percent of all infants born in the United States.
- Children up to their 5th birthday.

Benefits

The following benefits are provided to WIC participants:

- Supplemental nutritious foods
- Nutrition education and counseling at WIC clinics
- Screening and referrals to other health, welfare and social services

Program Delivery

WIC is not an entitlement program as Congress does not set aside funds to allow every eligible individual to participate in the program. WIC is a Federal grant program for which Congress authorizes a specific amount of funds each year for the program. WIC is:

- Administered at the Federal level by FNS
- Administered by 90 WIC state agencies, through approximately 47,000 authorized retailers.
- WIC operates through 1,900 local agencies in 10,000 clinic sites, in 50 State health departments, 34 Indian Tribal Organizations, the District of Columbia, and five territories (Northern Mariana, American Samoa, Guam, Puerto Rico, and the Virgin Islands).

Examples of where WIC services are provided:

- County health departments
- Hospitals
- Mobile clinics (vans)
- Community centers
- Schools
- Public housing sites
- Migrant health centers and camps
- Indian Health Service facilities

Delaware Department of Education
Child and Adult Care Food Program (CACFP)

CHILD INCOME ELIGIBILITY FORM

PART 1 (Complete one application per household. Please use a pen, not a pencil.)

Definition of **Household Member**: "Anyone who is living with you and shares income and expenses, even if not related."

Children in **Foster care** and children who meet the definition of **Homeless, Migrant** or **Runaway** are eligible for free meals. Read **How to Apply for Free and Reduced Price School Meals** for more information.

Child's First Name	MI	Child's Last Name	Date of Birth	Ethnicity Hispanic or Latino? Yes	No	Race (check one or more) American Indian or Alaskan Native	Asian	Black Or African American	Native Hawaiian or Other Pacific Islander	White	Foster Child	Homeless, Migrant, Runaway
				☐	☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐	☐

PART 2 - ENROLLMENT

Start Date:		Arrival Time:		AM/PM	Departure Time:		AM/PM	Shift Work:	Yes/No

Normal days of week Participant(s) is/are in care *(circle all that apply)*: Mon Tues Wed Thurs Fri Sat Sun

Meals eaten at Providers/Center: *(Circle all that apply. CACFP provides reimbursement for up to 2 approved meals and one snack per day/participant)*:

Breakfast | AM Snack | Lunch | PM Snack | Supper | Evening Snack

PART 3 – HOUSEHOLD INCOME

Do any Household Members (including you) currently participate in one or more of the following assistance programs: SNAP or TANF?
Check one: ☐ Yes / ☐ No

If you answered NO – Complete STEP 3. **If you answered YES** – Write a case number below, then go to STEP 4
Case Number: (Write only one case number in this space)

A. Child Income
Sometimes children in the household earn income. Please include the TOTAL income earned by all Child Household Members listed in PART 1 here.

Child Income	How Often? Weekly	Bi-Weekly	2x Month	Monthly
$	☐	☐	☐	☐

B. All Adult Household Members (including yourself)
List all Household Members not listed in STEP 1 (including yourself) **even if they do not receive income.** For each Household Member listed, if they do receive income, report total income for each source in whole dollars only. If they do not receive from any source, write "0". If you enter "0" or leave any fields blank, you are certifying (promising) that there is not income to report.

Name of Adult Household Members (First/Last)	Earnings from Work (Before Deductions)	How Often? Weekly	Bi-Weekly	2x Month	Monthly	Public Assistance/ Child Support/ Alimony	How Often? Weekly	Bi-Weekly	2x Month	Monthly	Pensions/SSI/ Retirement/ All Other Income	How Often? Weekly	Bi-Weekly	2x Month	Monthly
1	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
2	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
3	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
4	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
5	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐

Total Household Members (Children and Adults)		Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household	* * * - * * - ____	Check if No SSN ☐

PART 4 – CONTACT INFORMATION and ADULT SIGNATURE

An adult household member must **sign and date** this form before it can be approved.
"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that school officials may verify (check) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Street Address (if available)	City	State	Zip	Daytime Phone and Email (optional)
Printed Name of adult completing the form	Signature of adult completing the form			Today's Date

SPONSOR USE ONLY:

Categorical Eligibility (If Yes, Check One): ☐ SNAP (Food Stamp) Household
☐ TANF Household ☐ Head-Start ☐ ECAP ☐ Foster Child(ren) ☐ Homeless/Migrant/Runaway Participant(s)

DATE WITHDRAWN: _____

Total Family Income: _____ Family Size: _____ (Include all Participants)
Yearly Income Conversion: **Weekly x 52; Every Two Weeks x 26; Twice a Month x 24; Monthly x 12**

ELIGIBILITY - Based on the information provided this application will be:
☐ Approved FREE ☐ Approved REDUCED ☐ Denied – The meals will be claimed in the PAID category.

Determining Official Signature: _____ Review/Effective Date: _____

STATE OF DELAWARE
DEPARTMENT OF SERVICES FOR CHILDREN,
YOUTH AND THEIR FAMILIES
OFFICE OF CHILD CARE LICENSING

Family Child Care
Large Family Child Care Home
Day Care Center

NAME_____

BIRTHDATE_____

CHILD HEALTH APPRAISAL

SECTION A: TO BE COMPLETED BY PARENT BEFORE PHYSICAL EXAMINATION

CHECK IF CHILD HAS PROBLEMS WITH ANY OF THE FOLLOWING: GIVE ADDITIONAL COMMENTS BELOW

❑ Allergies (food, medicine, bee sting etc.)	❑ Frequent Colds	❑ Fainting	❑ Physical Handicap
	❑ Hearing Difficulty	❑ Speech Difficulty	❑ Behavior Problem
❑ Constipation/Diarrhea	❑ Seizures	❑ Vision Difficulty	❑ Asthma

Other_____

Comments:_____

ADDITIONAL INFORMATION ABOUT YOUR CHILD (include serious illness, accidents, operations, medications, etc. with dates):

_____

_____

Parent/Guardian's Signature_____ Date_____

SECTION B: TO BE COMPLETED BY EXAMINING PHYSICIAN/PEDIATRIC NURSE PRACTITIONER

CODE: X - Within Normal Limits O - See Remarks Below

_____ Scalp, Skin	_____ Heart	_____ Vision	_____ Ear, Nose	_____ Lungs
_____ Hearing	_____ Throat	_____ Abdomen	_____ Blood Pressure	_____ Eyes
_____ Genitalia	_____ Teeth	_____ Extremities	_____ Neck, Glands	_____ Nervous System
_____ Height	_____ Weight			

REMARKS AND RECOMMENDATIONS: _____

_____

IS CHILD PROGRESSING NORMALLY FOR AGE GROUP? _____

DTP/Hib 1 / /	DTP/Hib 2 / /	DTP/Hib 3 / /	DTP/ Hib 4 / /	DTaP/Hib 4 / /
DTP/DTaP 1 / DT / /	DTP/DTaP 2 / DT / /	DTP/DTaP 3 / DT / /	DTP/DTaP 4 / DT / /	DTP/DTaP 5 / DT / /
Td 1 / /	Td 2 / /	Td 3 / /	/ /	/ /
OPV/IPV 1 / /	OPV/IPV 2 / /	OPV/IPV 3 / /	OPV/IPV 4 / /	TB Screening 12 mo / /
MMR 1 / /	MMR 2 / /	HepB 1 / /	HepB 2 / /	HepB 3 / /
Hib 1 / /	Hib 2 / /	Hib 3 / /	Hib 4 / /	Hep B/Hib 1 / /
Hep B/Hib 2 / /	Hep B/Hib 3 / /	Varicella 1 / /	Varicella 2 / /	Influenza 1 / /
Influenza 2 / /	Pneumococcal Polysaccharide1 / /	Pneumococcal Polysaccharide 2 / /	Pneumococcal Conjugate 1 / /	Pneumococcal Conjugate 2 / /
Pneumococcal Conjugate 3 / /	Pneumococcal Conjugate 4 / /	Hep A 1 / /	Hep A 2 / /	Lyme Vax 1 / /
Lyme Vax 2 / /	Lyme Vax 3 / /	Other: / /	Lead Screening 12 mo / /	

Examiner's Signature_____ ❑ M.D. ❑ P.N.P. Date:_____

Printed Name:_____ Telephone:_____

DOC.NO. 37-06-10-01-01-01