Sara Holbrook Community Center Early Education Program

Toddler Program Enrollment 2021/2022

Start Date_____

The following documents must be presented at the time of application

- Child's Birth Certificate
- Child's record of current physical & immunizations
- Custody Papers (if applicable
- Parent Picture I.D.
- Proof of Residency (lease, deed, or currently dated utility bill)

Office Use Only:
Application Received: _____
*Application Complete*_____

Student Name: _____
First Middle Last

Preferred Name: _____Gender: Male ☐ Female ☐ Transgender ☐ Unknown ☐

Date of Birth: _____

Country of Origin: _____ City of Birth: _____

Language(s)spoken at home_____ _____ _____

Race or Ethnicity: _____

Previously enrolled in Sara Holbrook? ☐ Yes ☐ No

Have you ever been enrolled in any other program? ☐ Yes. ☐ No

If yes, name of last program attended_____

Parent Information

Check answers that apply

Status of Parents/Guardians: ☐ Married ☐ Divorced ☐ Widowed. ☐ Separated ☐ Single/Never Married

If divorced who has legal custody? ☐ Mother ☐ Father. ☐ Shared Parenting

Primary Guardian

Name: _____

Address: *(if different from above)* _____

_____

Home Phone: _____

Cell Phone: _____

Email: _____

Place of Employment: _____

Work Phone: _____

Secondary Guardian

Name: _____

Address: *(if different from above)* _____

_____

Home Phone: _____

Cell Phone: _____

Email: _____

Place of Employment: _____

Work Phone: _____

Emergency Contacts

Must supply two. Need to be other than guardians.

Contact #1

Name: _____

Address: _____

Relationship to the child: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Contact #2

Name: _____

Address: _____

Relationship to the child: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Authorized To Pick Up Child

Please list no less than two

1st Contact/Pickup

Name: _____

Address: _____

Relationship to child: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

2nd Contact/Pickup

Name: _____

Address: _____

Relationship to child: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

3rd Contact/Pickup

Name: _____

Address: _____

Relationship to child: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

4th Contact/Pickup

Name: _____

Address: _____

Relationship to child: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Current Health Problems

See Asthma, Diabetes, and Seizures on pp. 3 & 4

Please list any medical conditions we should be aware of including conditions in the past year (hearing/vision problems, surgeries, wearing glasses (for near or farsightedness), broken bones, etc.)

_____

_____

** All medication must be accompanied by a completed and signed medication form, which is to be obtained from Main Office.

In the event of an emergency

Please list your insurance company, policy number, as well as your child's medical and dental professionals. We will only make use of this information if you or the previously listed people cannot be reached in an emergency. If needed, we will call 911 first.

Insurance: _____ Policy# _____

Child's Doctor: _____ Phone: _____

Child's Dentist: _____ Phone: _____

Child's Orthodontist: _____ Phone: _____

Waiver & Medical Authorization

I attest that the information above is true and correct to the best of my knowledge, and I am fully aware of the risk inherent. I hereby give my consent for my child, listed above, to participate in the SHCC Early Education Program. The person herein described has permission to engage in all activities, except as noted. I agree to hold harmless the Sara Holbrook Community Center, its employees, or volunteers from any and all liability from any injury, claims, costs, or loss of service which might be incurred by participation in said programs, related activities or events. I understand that medical insurance coverage is not provided. I hereby give permission to the program to provide routine health care (including the application of non-prescription medications and products, ointments, creams, tick and insect repellents, sunscreen and other topically applied ointments and lotions as deemed necessary). I agree to the release of any of the above-described information for the necessary treatment, referral, billing, or insurance purposes. In the event of an emergency, I hereby give permission to the program to arrange necessary related transportation for my child and give permission to the attending physician to secure and administer treatment, including hospitalization.

☐ **Yes** ☐ **No** **Parent/Guardian Initials** _____

Allergies

☐ **Yes** ☐ **No**

Allergy type:

☐ Food – List food(s): _____

☐ Medication – List medication(s): _____

☐ Minor stings or insect bites

☐ Other – List: _____

Date of last severe reaction: _____

Food Restrictions

☐ Yes ☐ No

☐ Due to gastrointestinal (digestive) distress. List food(s): _____

☐ Due to religious or other preferences. List food(s): _____

Asthma

☐ Yes ☐ No

If currently prescribed medication and treatments for asthma, please send in current *asthma medication*** and equipment in original box with student's name on it. A current asthma action plan must be on file in the Main Office.

☐ Daily control (preventative) medication**

☐ As needed medication** Please circle: exercise-induced cold-induced other_____

Date of last hospital or emergency room visit due to asthma: _____

All medication must be accompanied by a completed and signed medication form, which is to be obtained from Main Office

Diabetes

☐ Yes ☐ No

Date of last hospital or emergency room visit due to diabetes: _____

Does the student's diabetes require medication and/or blood testing in school?

☐ No ☐ Yes List medication(s)**: _____

All medication must be accompanied by a completed and signed medication form, which is to be obtained from Main Office

Seizure Disorder

☐ Yes ☐ No

A current seizure action plan must be on file in the Main Office.

Does the student's seizure disorder require medication in school? ☐ No. ☐ Yes

List medication(s)**: _____

(name) (dosage) (route) (time to be given)

Date of last seizure: _____

Date of last hospital or emergency room visit due to seizure: _____

All medication must be accompanied by a completed and signed medication form, which is to be obtained from Main Office

Immunization Records

☐ Yes ☐ No **Parent/Guardian Initials** _____

(It is a licensing requirement that the Sara Holbrook Community Center have a copy of your child's immunization records on file at our program.) I give permission for the Sara Holbrook Community Center to access my child's immunization records through the Vermont Immunization Registry.

Photo Consent

☐ Yes ☐ No. **Parent/Guardian Initials** _____

I hereby irrevocably give my consent to Sara Holbrook Community Center and to such other persons as they may designate, to use my child's name, verbal statements and portrait or picture (motion or still)for public relations, advertising purposes or for any lawful purpose whatever, in any media now know or hereafter developed.

Photo Consent for Student Portfolios

☐ Yes ☐ No. **Parent/Guardian Initials** _____

SHCC Early Education Program may take photographs of my child to put in their portfolios. (*A student portfolio is all of the student's work along with pictures of them throughout the year working and playing with friends bound into a book to be presented to the student at the end of the school year.*)

Waiver for Participant by Parent/Guardian

In consideration of your accepting my child's entry, I hereby, for myself, my child, my heirs, executors and administrators, waiver and release any and all rights and claims for damages I or my child may have against the Burlington Parks District, the Burlington School District, or the Sara Holbrook Community Center and its representatives, successors, and assigns for any and all injuries suffered by myself or my child at any activity sponsored by the school.

☐ Yes ☐ No

I have read the above carefully and sign it voluntarily with full knowledge of its significance.

Name of Child: _____ Child's Date of Birth; _____

Parent/Guardian's Name Printed: _____

Parent/Guardian's Signature: _____Today's Date: _____

Household Income Information

Needed for grants and other program reporting requirements

How many people live in the household? _____

Please list the name and age of all the people living in the household:

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Parent/Guardian #1 Name:			
Type of Income	**YES***	**NO**	**Gross Amount**
Wages (Job 1) Employer:			
Wages (Job 2) Employer:			
Child Support			
Reach Up			
Social Security Benefits			
Unemployment			
Worker's Compensation			
Other (rental income, self-employment, veterans' benefits, etc.)			

Parent/Guardian #1 Name:			
Type of Income	**YES***	**NO**	**Gross Amount**
Wages (Job 1) Employer:			
Wages (Job 2) Employer:			
Child Support			
Reach Up			
Social Security Benefits			
Unemployment			
Worker's Compensation			
Other (rental income, self-employment, veterans' benefits, etc.)			

I certify that that above income information is correct.

Parent Signature _____ **Date:** _____

Tuition/$231.54 per week

☐ I receive childcare subsidy for tuition payment.

☐ I need to apply for childcare subsidy. (Please see Early Ed Director for information)

☐ I receive partial or no subsidy and am interested in a tuition scholarship.

Consent Form For the Release of a Student's Education Records

I, _____ (Parent name), give permission to the staff of the Sara Holbrook Community Center to share relevant information with the _____ School District. The SHCC agrees to notify the parent about any information that is shared.

Specifications of the education records to be disclosed: Any and all education records of the student maintained by SHCC agrees to notify the parent about any information that is shared.

My signature below demonstrates my consent to the release of the above-named student's records. This consent is valid from September 1st, 2021 to August 31st, 2022.

_____ _____

Signature of Parent/Guardian of Eligible Student Date

• First and last name • Date of birth • Student ID number • Race/ethnicity • Gender • IEP • Bilingual/Limited English Proficiency • Parent/guardian name • Email address(es)	• School attending • Phone numbers • Special education • Progress Monitoring Assessment Data • Student behavior data • Student behavior data • Student Attendance • Medical Records (including immunizations) • Address

I. **The purpose(s) of disclosure is/are:** To improve instruction and other out-of-school time services that promote the Student's success in school, to meet the needs of the Student more effectively, to equitably support students from all demographic segments of the population, to identify gaps in service, and determine whether these programs are supporting student achievement in alignment with educational needs as well as creating a culture of positive behavior and strong youth engagement.

My signature below demonstrates my consent to the release of the above named Student's education records to the Sara Holbrook Community Center Early Education Program, all as more fully described above. This Consent is valid from September 1 through August 31 of the current school year.

_____ _____

Signature of Parent/Guardian of Eligible Student Date

Copies of the Disclosed Education Record(s) are available upon request to parent(s). If you have any questions regarding this request, please call your child's school.

Anything else you would like to share?