CALVARY TEMPLE

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Early Childhood Learning Center

3436 Winchester Rd, Allentown, PA 18104 • Phone: 610.841.7988 • Fax: 610.398.0417 • Web: www.cteclc.org

Enrollment Packet

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Admissions Checklist

Please review and complete checklist during the admission process

- [ ] Getting to Know You Form
- [ ] ASQ Parent / Guardian Consent Form
- [ ] Parent Handbook; return signature page
- [ ] Enrollment Application
- [ ] Photo Release Form
- [ ] Agreement
- [ ] Child Health Report (due within 30 days of enrollment)
- [ ] Infant Feeding Information Sheet
- [ ] Emergency Contact Sheet
- [ ] Email Contact Sheet
- [ ] Food Program Forms (CACFP Eligibility Form, CACFP Enrollment Form)
- [ ] Registration Fee and Security Deposit
- [ ] Emergency Management Plan Document
- [ ] IEP / IFSP Information Sheet
- [ ] Tuition Express Form
- [ ] Application for Scholarship

Once completed please sign below. Any outstanding documents, please notify the Director. Thank you.

Signature _____ Date _____

2016

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Toddler Classroom	
1 to 2 years old	
Weekly (up to 10 hrs/day)	Daily (up to 10 hrs/day, 2 day minimum)
$183.25	$41.25

Beginner Classroom	
2 to 3 years old	
Weekly (up to 10 hrs/day)	Daily (up to 10 hrs/day, 2 day minimum)
$178.25	$40.25

Preschool Classroom	
3 to 4 years old	
Weekly (up to 10 hrs/day)	Daily (up to 10 hrs/day, 2 day minimum)
$173	$39.75

Pre-K Classroom	
4/5 years old to start of K	
Weekly (up to 10 hrs/day)	Daily (up to 10 hrs/day, 2 day minimum)
$173	$39.75

2016

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Additional Rates Schedules for School Age & Kindergarten
Before & After School

School Age			
# of Days/Wk	Before School	After School	Before & After School
5 days	$82.50	$92.75	$110.25
Daily/2 day min	18	$21.75	$25.75

Kindergarten			
# of Days/Wk	Before AM Kindergarten	After AM Kindergarten	Before & After Kindergarten
5 days	$91.75	$141.25	$152.50
Daily/2 day min	$19.75	$31	$35

Half Day Rates (< 5 hours/day)	
5 days	Daily/2 day minimum
$146.25	$33

Camp Calvary Summer Camp for School Age (6-12)	
5 days	Daily/3 day minimum*
$155	$34.80

*Minimum commitment of 3 weeks.

Dear Parent,

Please help me help your child through orientation by completing this form.

Child's Name _____

Please list your child's favorite…

Breakfast food _____
Lunch food_____
Snack food _____
Song _____
Books _____
Videos _____
Toy or stuffed animal _____
Cartoon character _____
Game _____
Inside activity _____
Outside activity _____
If my child has trouble falling asleep I usually: _____
_____
My child is afraid of: _____

Other people who have regular contact and are involved with my child's care (grandparents, step parents, siblings, friends, etc.)…

Name _____Relationship _____
Name _____Relationship _____
Name _____Relationship _____
Name _____Relationship _____

Anything else you would like to share about your child to help him/her feel more comfortable (especially in the first week when we are brand new to each other)…

_____
_____
_____
_____
_____

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website: www.calvarytemplelearningcenter.com

ASQ Parent / Guardian Consent Form

The Ages and Stages Questionnaire (ASQ) is a parent-report developmental screening consisting of series of questionnaires that screen and monitor a child's development between the ages of two months to five years olds. The activities discussed in each questionnaire reflect the developmental milestones for each age group. Questions will address all areas of development: communication, fine and gross motor skills, problem-solving, and personal social. Questionnaires may be used at a single point in time for a one-time screening or at numerous intervals for ongoing monitoring.

The results can assist in determining if the child is developing on track or if the child may need a more in depth assessment to identify the need for specialized services. Research has shown that the sooner children are identified as needing additional services to address delays and the sooner they get help, the better the child's chance of making significant developmental strides.

If you have any questions or concerns please contact the center Director at 610-841-7988.

_____ _____

Child's name Date of birth

I understand my signature below gives consent for my child to participate in a developmental monitoring program using the standardized Ages and Stages Questionnaire.

_____ _____

Parent/Guardian Signature Date

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"No Bully" Policy – Parent Sign Off

Calvary Temple ECLC has a "No Bully" policy. There will be zero tolerance for any kind of violence, degradation, harassment, vulgarity, ridicule or obscenity on the part of children, parents, or staff. Violation of this policy will result in immediate dismissal from the center.

I have read and understand the "No Bully Policy" that is in effect for Calvary Temple Early Childhood Learning Center. I agree to follow policies and procedures.

_____ _____

Parent Signature *Date*

Sickness Policy – Parent Acknowledgment

If your child has fever of 100.4 or higher, an unknown rash, vomiting, a runny nose (anything but clear), lethargy, the flue, pink eye, diarrhea (2 loose bowel movements in 2 hours) you will be notified that your child must be picked up within the hour. Your child will be removed from his/her room and sent to the Director's Office where he/she will stay until a parent or authorized person arrives. We require a note from a doctor for pink eye and any other contagious illnesses, releasing the child from medical care and allowing the child to return to care. Your child may return to the center after they have been feer or symptom free without the use of medications for at lest the duration of 24 hours.

I have read and understand the "Sickness Policy" that is in effect for Calvary Temple Early Childhood Learning Center. I agree to follow policies and procedures.

_____ _____

Parent Signature *Date*

I have read and understand the Calvary Temple ECLC Parent Handbook in its entirety. I agree to follow all policies and procedures as defined.

_____ _____

Parent Name *Parent Signature*

_____ _____

Date *Witness*

Enrollment Application

Date: _____

Child's Name: _____

Birth Date: _____

Parents/Guardians: _____

_____

Mailing Address: _____

_____

Home Number: _____

Work Number: _____

Your Child's Assigned Room is: _____

Child's Schedule for Care:
(Refer to agreement options)

Full Time Part-time Flex Drop In

Days Child Will Be Attending:

Monday Tuesday Wednesday Thursday Friday

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Permission/Photo Release Form

CTECLC Release

Of consideration of my engagement as a model, and for other good and valuable consideration herein acknowledged as received, I hereby grant to CTECLC his/her heirs, legal representatives and assigns, those for whom Photographer is acting and those acting with his authority and permission to irrevocalbe and unrestricted right and permission to take, copyright in his own name or otherwise, and use, re-use and re-publish photographic portraits or pictures of me or in which I may be included I whole or part, or composite or distorted in character or form without restriction as to changes or alteratons, in conjunction with my own or a fictitious name, or reporductions thereof in color or otherwise, made through any medium at his studios or elsewhere, an in any or all media now or hereafter known for illustration, promotion, art, editorial, advertising, or any purpose whatsoever, without further compensation. I also consent to the use of any published matter in conjunction therewith.

I hereby waive any right that I may have to inspect or approve the finished product or products that the advertising copy or other matter that may be used in conjunction therwith or the use to which it may be applied.

I hereby release, discharge and release CTECLC, his/her, heirs legal representatives and assigns, and all persons acting under his permission or authority or those for whom he is acting, from any liability by virtue of blurring, distortion, alteration, optical illusion, or use in composite form, whether intentional or otherwise, that may occur or be produced in the taking of said photograph or in an subsequent processing thereof, as well as any publication thereof, including without limitations any claims for libel or invasion of privacy.

I hereby give my child permission to use all the play equipment and participate in all activities of CTECLC. Only in an extreme emergence I give permission for my child to be transported.

I hereby warrant that I am of legal age and have the right to conract in my own name. I have read the above authorization, release and agreement, prior to its execution and am fully familiar with the contents there of. This release shall be binding upon me and my heirs, legal representatives, and assigns.

Date:_____ Name:_____

Witness:_____ Signature:_____

Client:_____ Address:_____

_____

AGREEMENT

55 PA CODE CHAPTERS 3270.123 &.181(C); 3280.123 &.181(c); 3290.123 &.181(c)

NAME OF CHILD		
FEE AMOUNT	PER-DAY-WEEK	DAY PAYMENT TO BE MADE **Fri. before week of service**

Services to be provided as part of the day care fee (examples; transportation, care, meals, etc.)

5 days/week of care

Care and Daily Activities, including physical, spiritual, and cognitive

Breakfast and PM Snack

Rest cot

TLC

CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIME	PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED
LATE FEE $1.00	PER MIN-HR Per MIN AFTER 6:30PM	

I, the parent/guardian;

✓received complete written program information at the time of enrollment (§ 3270.121, 3280.121, 3290.121)

✓agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at a minimum. (§ 3270.124, 3280.124, 3290.124)

SIGNATURE-OPERATOR	DATE	SIGNATURE-PARENT OR GUARDIAN	DATE

DATE OF CHILD'S ADMISSION	Periodic Review
DATE OF WITHDRAWAL	SIGNATURE-PARENT OR GUARDIAN — DATE

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:

☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG) ☐ YES ☐ NO	**NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.**	
	VISION (subjective until age 3)	
	HEARING (subjective until age 4)	
	LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:	SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:	TITLE:
PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.

APPLICATION & EMERGENCY CONTACT/PARENTAL CONSENT FORM

Child's Name: _____ Birth date: _____

Home School District: _____ County: _____

Child Lives with Mom: ____ Dad: ____ Both: _____ Primary Language: _____

Mother's Name/Legal Guardian: _____ Birth date_____

Home Phone: _____ Cell Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

Employer's Name: _____ Employer's Phone: _____ ext ____

Employer's Address: _____ City: _____ State: ____ Zip: _____

Mother's/Legal Guardian's Email Address: _____

Father's Name/Legal Guardian: _____ Birth date_____

Home Phone: _____ Cell Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

Employer's Name: _____ Employer's Phone: _____ext ____

Employer's Address: _____ City: _____ State: ____ Zip: _____

Father's/Legal Guardian's Email Address: _____

PERSON (S) TO WHOM CHILD MAY BE RELEASED AND/OR CONTACTED IN CASE OF EMERGENCY (OTHER THAN PARENTS): **Please complete full address and list ALL phone numbers (home/work/cell)**

_____
Name Address

_____
Phone (H) Phone (W) Phone (C)

_____
Name Address

_____
Phone (H) Phone (W) Phone (C)

_____
Name Address

_____
Phone (H) Phone (W) Phone (C)

_____
Name Address

_____
Phone (H) Phone (W) Phone (C)

_____
Name Address

_____
Phone (H) Phone (W) Phone (C)

NAME & ADDRESS OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER:

_____ Telephone: _____

_____

HEALTH INSURANCE: _____
Insurance Name Policy # Group #

EMERGENCY MEDICAL INFORMATION: _____

Preferred Hospital: _____

ALLERGIES: _____ DIET RESTRICTIONS: _____

ALLERGIC REACTIONS: _____

IF APPLICABLE,
I GIVE PERMISSION TO THE CALVARY TEMPLE ECLC TO ADMINISTER THE FOLLOWING MEDICATIONS, SUNSREEN, AND CREAMS:

SIGNATURE

EPI PEN PROVIDED: _____ EXPIRATION DATE: _____

INHALER PROVIDED: _____

NEBULIZER NEEDED: _____

SUNSCREEN PROVIDED _____ EXPIRATION DATE: _____

DIAPER CREAM PROVIDED _____ EXPIRATION DATE: _____

PARENT INITIAL IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT:
Obtaining Emergency Medical Care: _____ Water Play: _____ Walks: _____
Administration of Minor First-Aid Procedures: _____ Posting of Allergies/Diet Restrictions: _____
Photos of child for use by Center: _____

Transportation by the Facility (School Age ONLY, if needed): _____

_____
Signature of Parent or Guardian Date

Do Not Sign until REVIEW: (semi-annual review of information)

I reviewed and corrected, if necessary, the above emergency information.

_____
Signature of Parent or Guardian Date

Email Contact Information

Child's Name: _____

Parent's Name: _____

Email Address: _____

I give my permission for CTECLC to contact me through my email address.

_____

Parent Signature Date

Child and Adult Care Food Program -- Child Enrollment Form

Enrollment Date:_____

Child _____	**Parent/Guardian** _____
Address _____	Address _____
_____	_____
Birth date _____	Telephone (home)_____(work)_____

Sponsoring Organization __CTECLC _____	**Center/Home** _____
Address _____3436 Winchester Rd_____	Address _____
_____Allentown, PA 18104_____	_____

Normal Hours of Care: (write in times*) *If more than 8 hours of care per day, please attach an explanation to this form.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Start: End:	Start: End:	Start: End:	Start: End:	Start: End:	Start: End:	Start: End:

Daily Expected Meal Service Participation (please check box)

Breakfast	AM Snack	Lunch	PM Snack	Supper	Eve Snack

Is this child of school age? ___Yes ___No If yes, will additional meals be provided when school is not in session? ___Yes ___No
If yes, please specify the meal: ___Breakfast ___Lunch ___Snack ___Supper

Household Contacts: This child care facility participates in the Child and Adult Care Food Program. In order to receive federal funds, representatives of the sponsoring organization or the State Agency may contact you to verify your child's participation. Please indicate what time and method of contact you prefer:

_____Day _____Evening _____Time _____Letter Telephone: _____ (home) _____ (work)

****

Annual Time Period Covered by Signature: _____10/1/12_____ **to** _____9/30/13_____

Signature Parent/Guardian_____ **Date** _____

Signature Center Administrator/Home Provider_____ **Date** _____

****

Annual Time Period Covered by Signature: _____ **to** _____

Signature Parent/Guardian_____ **Date** _____

Signature Center Administrator/Home Provider_____ **Date** _____

****

Annual Time Period Covered by Signature: _____ **to** _____

Signature Parent/Guardian_____ **Date** _____

Signature Center Administrator/Home Provider_____ **Date** _____

****

Annual Time Period Covered by Signature: _____ **to** _____

Signature Parent/Guardian_____ **Date** _____

Signature Center Administrator/Home Provider_____ **Date** _____

****

"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 or disability. (Not all prohibited bases apply to all programs)." "To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer."

For Sponsor Use Only
Child withdrew on _____

INSTRUCTIONS FOR COMPLETING THE CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM

Follow these instructions, if your household gets FOOD STAMPS, TANF, FDPIR, SSI or Medicaid:

Part 1: For family day care home and child care center, list participant's name and a Food Stamp, TANF or FDPIR case number. For adult day care, list participant's name and a Food Stamp, TANF, FDPIR, SSI or Medicaid case number.
Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Sign the form. A Social Security Number is not necessary.
Part 5: Answer this question if you choose to.

If you are applying on behalf of a FOSTER CHILD, use a separate application for each foster child and follow these instructions:

Part 1: Enter the child's name.
Part 2: Please contact us at **[Phone Number]**.
Part 3: Skip this part.
Part 4: Sign the form. A Social Security Number is not necessary.
Part 5: Answer this question if you choose to.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:

Part 1: List each participant's name.
Part 2: Skip this part.
Part 3: Follow these instructions to report total household income from last month.
Column A–Name: List the first and last name of **each** person living in your household, related or not (such as grandparents, other relatives, or friends who live with you). You must include yourself and all children living with you. Attach another sheet of paper if you need to.
Column B–Gross income last month and how often it was received. Next to each person's name, list each type of income received last month, and how often it was received.
In Box 1, list the **gross income** each person earned from work. This is not the same as take-home pay. **Gross income is the amount earned before taxes and other deductions.** The amount should be listed on your pay stub, or your boss can tell you. Next to the amount, write how often the person got it (weekly, every other week, twice a month, or monthly).
In box 2, list the amount each person got last month from welfare, child support, alimony.
In box 3, list Social Security, pensions, and retirement.
In box 4, list ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits, regular contributions from people who do not live in your household. Report net income for self-owned business, farm, or rental income. Next to the amount, write how often the person got it. If you are in the Military Housing Privatization Initiative do not include this housing allowance.
Column C–Check if no income: If the person does not have any income, check the box.
Part 4: An adult household member must sign the form and list his or her Social Security Number, or mark the box if he or she doesn't have one.
Part 5: Answer this question if you choose to.

Privacy Act Statement: This explains how we will use the information you give us.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.

Part 1. Children or adults enrolled to receive day care. (Use a separate application for each foster child)

Names (First, Middle Initial, Last)	Food Stamp, TANF or FDPIR case # for children only. All the above or SSI or Medicaid case # for adults only. **Skip to Part 4 if you listed a case #.**

Part 2. Foster Child: In certain cases, foster children are eligible for free and reduced-price meals regardless of household income. If foster children live with you, please contact **[name]**and **[phone number]**. Skip to Part 4.

Part 3. Total Household Gross Income—You must tell us how much and how often

A. Name (List everyone in household, including children)	B. Gross income and how often it was received *Example: $100/monthly $100/twice a month $100/every other week $100/weekly*				C. Check if NO income
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Social Security, pensions, retirement,	4. All Other Income	
(Example) Jane Smith	$200/weekly	$150/weekly	$100/monthly	$ /	☐
	$ /	$ /	$ /	$ /	☐
	$ /	$ /	$ /	$ /	☐
	$ /	$ /	$ /	$ /	☐
	$ /	$ /	$ /	$ /	☐
	$ /	$ /	$ /	$ /	☐
	$ /	$ /	$ /	$ /	☐
	$ /	$ /	$ /	$ /	☐

Part 4. Signature and Social Security Number (Adult must sign)
An adult household member must sign this form. If Part 3 is completed, the adult signing the form must also list his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.)
I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: X_____ Print name:_____ Date: _____

Address:_____ Phone Number:_____

Social Security Number: ___ - ___ - ____ ☐ I do not have a Social Security Number

Part 5. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
☐ Hispanic or Latino ☐ Not Hispanic or Latino	☐ Asian ☐ White ☐ Black or African American	☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12
Total Income: _____ Per: ☐ Week, ☐ Every 2 Weeks, ☐ Twice A Month, ☐ Month, ☐ Year Household size: _____
Categorical Eligibility: _____ Date Withdrawn: _____ Eligibility: Free___ Reduced___ Denied___ Tier I_____ Tier II____
Reason: _____
Temporary: Free_____ Reduced_____ Time Period: _____(expires after _____ days)
Determining Official's Signature: _____ Date: _____
Confirming Official's Signature: _____ Date: _____
Follow-up Official's Signature: _____ Date: _____

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM

The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.

Household size	Yearly
1	$20,036
2	$26,955
3	$33,874
4	$40,793
5	$47,712
6	$54,631
7	$61,550
8	$68,469
Each additional person:	+$6,919

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the social security number of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Food Stamp, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for your child or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: 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, or disability. To file a complaint of discrimination, write to *USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington DC 20250-9410* or call (800) 795-3272 or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

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Calvary Temple Learning Center
Registration Fee and Security Deposit

I hereby acknowledge that I have been informed the $50 registration fee, as well as the security deposit of first and last week tuition, is non-refundable and is due before date of enrollment. The total fee will be $_____.

Signature:_____ Date:_____

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Phone: 610.841.7988 Fax: 610.841.7989 Web: www.calvarytemplelearningcenter.com

Emergency Management Plan

To the Parent(s)/Guardian(s) of Calvary Temple Early Childhood Learning Center Children:

This letter is to assure you of our concern for the safety and welfare of the children attending Calvary Temple Early Childhood Learning Center. Our Emergency Plan provides for response to all types of emergencies. Depending on the circumstances of the emergency, we will use one of the following protective actions:

- **Immediate Evacuation:** Students will be evacuated to a safe area on the grounds of the facility in the event of a fire, etc.
- **In – Place Sheltering:** Sudden occurrences, weather or hazardous materials related, may dictate that taking cover inside the building is the best immediate response.
- **Evacuation:** Total evacuation of the facility may become necessary if there is a danger in the area. In this case, children will be taken to the relocation facility at Parkland Senior High School.
- **Modified Operation:** May include cancellation/postponement or rescheduling of normal activities. These actions are normally taken in case of a winter storm or building problems (such as utility disruptions) that make it unsafe for children but may be necessary in a variety of situations.

Please listen to WFMZ/Channel 69 News for announcements relating any emergency actions listed above.

We ask that you do not call during the emergency. This will keep the main telephone free to make emergency calls and relay information.

The facility director may provide an alternate phone number (i.e. cell phone, etc.) to call in an emergency event.

The form designating persons to pick-up your child is included with this letter for you to complete and have back to the day care facility no later than three (3) days after registration. This form will be used every time your child is released. Please ensure that only those persons you list on the form attempt to pick up your child.

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We specifically urge you NOT to attempt to make different arrangements during an emergency. This will only create additional confusion and divert staff from their assigned emergency duties.

In order to assure the safety of your children and our staff, we ask your understanding and cooperation. Should you have any additional questions regarding our emergency operating procedures, contact the center director at 610.841.7988.

Sincerely,

Director
Calvary Temple Early Childhood Learning Center

CALVARY TEMPLE

"BUT GOD"

Early Childhood Learning Center

INDIVIDUALIZED EDUCATION PLANS (IEP) & INDIVIDUALIZED FAMILY SERVICE PLANS (IFSP) INFORMATION SHEET

Because of the diverse set of needs of the children in your program, it is important to gather as much information about the best ways to educate each child. IEP's and IFSP's are created by service providers working with children with special needs and include this information. The Keystone STARS Performance Standards therefore require each early learning provider to request copies of IEP's and IFSP's for the children in their care. This request should be made as early as possible.
The information found on an IEP/IFSP is protected by privacy laws including the Health Insurance Portability and Accountability Act (HIPAA). Releases of information may also be required to speak to members of a child's treatment team. Professional development regarding privacy issues, and HIPAA in particular, is highly recommended.

Parent Sign-off Sheet

Child's Name:_____

Your child's growth and development is measured with developmental assessments. If your child currently has an IEP/IFSP, it would be beneficial to share a copy of this plan with us so we can work together to ensure that the guidelines are put into practice. You do not have to provide this information if you do not wish to do so.

☐ I am providing a copy of my child's IEP or IFSP.

☐ I am not providing a copy of my child's IEP or IFSP and/or this is not applicable to my child.

Signature:_____ **Date:**_____

Printed Name:_____

KEYSTONE STARS

Tuition Express

Convenient and Safe On-time Payments

procare SOFTWARE

PARENT FAQS

We are excited to offer automatic payments through Tuition Express. It is no longer necessary for you to write a check for tuition and fees. Your bank or credit card account will be safely and securely debited by Tuition Express. You can be emailed a receipt for each transaction. It's easy to sign-up – just ask us.

Frequently Asked Questions

When I pay my tuition automatically, how secure is my account information?
Very secure – more secure than when you write checks. The checks you write every day have your name, address, phone number, and sometimes your driver's license number on them. With this information, criminals have all they need to access your account or worse, steal your identity. Automatic payments greatly reduce this potential problem by limiting the amount of information available and who has access to it. Tuition Express also incorporates additional security procedures, utilizing 128 bit encryption.

What if the childcare center makes a mistake and takes out too much money?
Report the error to your childcare center immediately – it was most likely an honest mistake. The childcare center will then adjust your account accordingly.

What if my childcare center and I disagree about a payment?
If you feel that the payment should not have been made, you have the right to dispute the charge. Contact your bank or credit card company. Tuition Express and your childcare provider will work closely to resolve the issue in a timely manner.

Does this form of payment give the childcare center access to my account?
Nobody at the childcare center has access to your account. When you sign up for Tuition Express, you only authorize your bank or credit card company to release the exact amount owed to your provider when it is due and payable.

How will I know when a payment was taken out of my account?
Your childcare expenses will be taken out of your account on a schedule that you and the childcare center agree upon. Your childcare center has the ability to print statements for your records prior to the withdrawal of any money. Additionally, the charges will show up on your monthly statement as "Tuition Express".

When I sign up for Tuition Express, how will this help my childcare provider?
Your childcare provider has chosen to offer Automatic Payments for several reasons. First, it will give you the convenience of not having to write a check every time tuition and fees are due. Second, it allows regular scheduling of your payments. Most importantly, Automatic Payments reduce the amount of time your childcare center spends on management activities, giving staff more time to spend with the children.

How do I get started?
Simply complete the "Payment Authorization" form and return it to your childcare provider. They will do the rest! For more information on automatic payments, visit www.directpayment.org. This is an excellent resource explaining the system and its benefits.

Where can I learn more?
For more information on the benefits of Tuition Express, please visit us at www.tuitionexpress.com.

Tuition® Express

Automated Payment Processing
Safe—Convenient—Easy

We are excited to offer the safety, convenience and ease of Tuition Express®–a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) _____ to initiate credit card charges to the below-referenced credit card account **(Section A)** OR, initiate debit entries to my (our) checking or savings account, indicated below **(Section B)**. To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

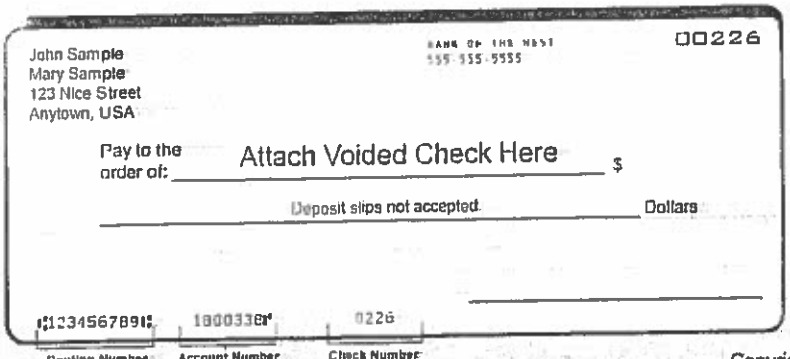
Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____

For Official Use Only

Date Received
Employee Signature



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APPLICATION FOR SCHOLARSHIP CALVARY TEMPLE EARLY CHILDHOOD LEARNING CENTER

To apply for Scholarship Assistance, you must complete all questions front and back and sign at the "X". Be sure your correct and complete name and address is entered below. If incorrect, cross out and print correctly in space provided below.

1 Please complete this section

FIRST NAME	MIDDLE INITIAL	LAST NAME	DATE OF BIRTH
STREET ADDRESS		APARTMENT	
CITY		STATE	ZIP CODE

2 Phone Number ( )_____ None ☐

3 Does anyone in your household receive financial assistance for a disability? ☐ Yes ☐ No

4 List the people who live with you. Start with yourself. Include all children and adults. Include related roomers. Include all unrelated roomers who share household expenses.

Use the codes below to help provide the details for all individuals in your household. Use additional sheets if needed. If you do not have or have a reason not to provide a Social Security number, complete the Grant/Scholarship Affidavit in the Certification Section on page 2.

CITIZENSHIP: (1) U.S. Citizen, (2) Permanent Alien, (3) Temporary Alien, (4) Refugee, (5) Other-not eligible for benefits (All non-U.S. citizens must provide proof of citizenship status.)

RACE (optional): (1) Black or African American, (3) American Indian or Alaskan Native, (4) Asian, (5) White, (6) Other, (7) Native Hawaiian or other Pacific Islander

ETHNICITY (optional): (1) Non-Hispanic, (2) Hispanic or Latino

NAME (Last, First, M.I.)	Date of Birth	Sex M	Sex F	Social Security Number	Citizenship	Race (Optional)	Ethnicity (Optional)	Relationship to You
								SELF
Total persons in household								

5 Are You

☐ Renting with heat not included
☐ Renting with heat included
☐ An unrelated roomer
☐ An owner or are you buying your home
☐ Renting subsidized housing/Section 8 housing with heat included
☐ Renting subsidized housing/Section 8 housing with heat NOT included
☐ Other: _____

IF HEAT IS INCLUDED IN YOUR RENT. ATTACH A NOTE FROM YOUR LANDLORD STATING THAT HEAT IS INCLUDED AS WELL AS WHAT TYPE OF FUEL IS USED.

6 Tell us about income for the people in your household. Please tell us about all income, before taxes and deductions.

Name of person with income	Kind of income	How much each month?
Name of person with income	Kind of income	How much each month?
Name of person with income	Kind of income	How much each month?

Name of person with income	Kind of income	How much each month?

Income includes money from: Employment, Veteran's Benefits, Unemployment Compensation, Black Lung benefits, Social Security, Support, Workers Compensation, Interest/Dividends, Rental Income, Child Support, etc.

We will use the income information you send us to see how much you earn in one year. Please send one of the following:

SEND PROOF FOR ONE MONTH OF INCOME IF YOUR INCOME IS THE SAME EVERY MONTH (SALARY, SOCIAL SECURITY, PENSION ETC.)

IF THE AMOUNT OF YOUR INCOME IS NOT THE SAME EVERY MONTH, PLEASE SEND PROOF OF YOUR INCOME FOR THE LAST THREE MONTHS.

IF YOU HAD SIGNIFICANT CHANGES IN INCOME OVER THE PAST 12 MONTHS (PERIODS OF UNEMPLOYMENT, CHANGES IN JOBS, SEASONAL WORK. ETC.), SEND PROOF OF YOUR INCOME FOR THE PAST 12 MONTHS.

IF YOU HAVE NO INCOME FOR THE PAST THREE MONTHS OR IF YOUR 'NCOME IS LESS THAN THE COST OF YOUR MONTHLY BASIC LIVING NEEDS, YOU MUST TELL US IN WRITING HOW YOU ARE PAYING FOR YOUR BASIC LIVING NEEDS (FOOD, SHELTER, PERSONAL ITEMS, ETC.)

PROOF OF INCOME INCLUDES PAY STUBS, AWARD LETTERS, EMPLOYER STATEMENTS. ETC.

7	Is anyone in the U.S. Military, or has anyone been in the U.S. Military? If yes, who? _____	☐ Yes ☐ No
	Is anyone a widow, spouse of child (under age 18) of anyone in the U.S. Military, or anyone who has been in the U.S. Military? If yes, who? _____	☐ Yes ☐ No

Certification

1. My signature on this application gives my permission to the Winchester Road Day Center or its authorized agent to: (a) check any information I give about where I live, my jobs, income, resources; (b) find out about the costs of my shelter, heating and heating use; and (c) complete any survey in connection with Grant/Scholarship.

2. If you fail to provide a Social Security Number or completed Energy Assistance Affidavit, you will not be eligible for benefits. I certify that: (check all that apply)

   ☐ I provided Social Security Numbers for all household members. To the best of my knowledge, these household members do not have Social Security Numbers:

   ☐ To the best of my knowledge, these household members do not have Social Security Numbers

   ☐ The following household members are exercising their rights under Section 7 of the Privacy Act of 1974, and refuse to disclose their Social Security Number:

   _____ Print Name _____ Print Name

   _____ Print Name _____ Print Name

   ☐ The following household members are exercising their rights under Section 7 of the Privacy Act of 1974, and refuse to disclose their Social Security Number:

   _____ Print Name _____ Print Name

   _____ Print Name _____ Print Name

3. I understand I have the right to appeal any decision or undue delay in decision which I consider improper regarding this application.

4. I affirm that Pennsylvania is my legal residence.

5. I understand any Social Security Number(s) given will be used in the administration of this program, including cross matches with other programs.

6. I understand that I will be sent a notice of eligibility or ineligibility and, if eligible, the notice will state the amount of my Grant/Scholarship.

7. I certify that, subject to penalties provided by law, the information I gave is true, correct and complete to the best of my knowledge.

8. I know that if I give false information, I can be penalized by loss of the Grant/Scholarship.

9. I understand by signing this application, I may not qualify because Grant/Scholarship money has run out.

Please Sign Here –Use Ink

X _____ Signature _____ Date