Your Child's World Before and After School Program

WELCOME LETTER

Welcome to Your Child's World Learning Center, Inc. Before and After School Program. Our main emphasis in offering this program is to provide your child with a fun and safe program for the before and after school hours. One of the key elements of this program is "play" – which is something that is sometimes forgotten in this busy world that we are raising our children in. Through the activities that we offer, we are hoping to help your children develop some lifelong leisure skills, as well as an understanding about the importance of having recreational interests. We are a family friendly program and invite any new ideas. It is the goal of the department to have the program run as smoothly and efficiently as possible. With your participation and cooperation, it will continue to be a premium recreational program. Activities will include indoor group games, arts and crafts, music, dance and some field trips. We understand that you have busy lives, and you have a lot going on. Please let us know if you would like your child to begin homework at our program.

Our program is open to children in Grades K- their 13th Birthday that attend the neighborhood schools that we service. Our Before School Program is offered from 6:00 – 8:30 a.m. Monday- Friday, excluding all holidays, teacher in-service days or snow days. Children will be dropped off to school between 8:00am and 8:30am. Breakfast will be given to all children who arrive to our program before 7:40am. Our After School Program is offered on Monday - Friday from 3:00 p.m. – 6:00p.m., excluding holidays, teacher in-service days or snow days. We do not provide will not be held on early release days due to snow.

Please feel free to contact any administrative team member if you have any questions or concerns. We are here to support you while you are at work.

Thank you,
Your Child's World Learning Center, Inc. Before and After School Program

Please complete the attached form, accompanied by supporting documentation. Completed applications will take a minimum of two (2) weeks to be processed. All applicants will be notified by phone/mail whether their child has a slot or if their child will be placed on the waiting list.

In order for us to determine your eligibility, we need to receive copies of the following information:

- Application: (Completed and signed)
- Child Birth Certificate
- Child Custody information/documents (if applicable)
- An Individual Learning Plan (IEP) if your child has a disability (if applicable)
- Child's health insurance card
- Picture ID of Parent/Guardian
- Health Assessment

These documents must be submitted to us before your application can be evaluated. Please submit COPIES only. Your child will not have the opportunity to be offered enrollment in the program nor have his/her name placed on the waiting list if his/her application is incomplete. To ensure that your application is complete, refer to the above list.

Please submit your Head Start application and copies of all required documents by using the following methods:

Mail or Hand Deliver To:

2nd Street Location
5837 N. 2nd Street
Philadelphia, PA 19120

Elmwood Location
2400 S. 71st Street
Philadelphia, PA 19142

Broad Street Location
7120 N. Broad Street
Philadelphia, PA 19126

Harbison Location
6596A Roosevelt Blvd.
Philadelphia, PA 19149

Roslyn Location
1052 Easton Road
Roslyn, PA 19001

Need help paying for childcare?

Contact CCIS
1430 Dekalb Street
Fifth Floor
Norristown, PA 19401
Ph: 610-278-3707
http://www.montcopa.org/index.aspx?nid=115

Do you want more tax money back?
Do you know what EITC (Earned Income Tax Credit) is?

EITC is for working people who earn less than $53,267. This year, the credit can be from $2 up to $6,242.
https://www.eitc.irs.gov/EITC-Central/publications

Your Child's World Learning Center, Inc.

School Age Before and After School Program Emergency Contact and Agreement

Child's Name		**Date of Birth:**	
Address:		____________________, PA ___________	
Mother's Name ○ **Foster Parent** ○ **Legal Guardian** **(Relationship to child)** ______________		**Contact Numbers** **Cell:** ____________________________________ **Work:** ____________________________________ **Home:**	
Address:		____________________, PA ___________	
Father's Name ○ **Foster Parent** ○ **Legal Guardian** **(Relationship to child)** ______________		**Contact Numbers** **Cell:** ____________________________________ **Work:** ____________________________________ **Home:** ____________________________________	
Address:		____________________, PA ___________	
Child's Physician		**Phone Number**	
Address:			

EMERGENCY CONTACTS AND PERSONS AUTHORIZED TO PICK CHILD:

Each person you authorize to pick up your child **must be 18 years or older and have a valid ID.**

Contact/Escorts Name	**Address**	**Phone Number**	**Parent's Initial and date authorized**

Allergies:	**Medical Conditions/Disabilities:**
Medications taken at home:	**Medications given to school with physician request and medication log completed:**

Nutrition/Dietary Restrictions	**Health Insurance Name and Policy Number**
SIGN BY EACH X BELOW TO GIVE CONSTENT:	
Daily Walks	**X**
Trips/Outings	**X**
Transportation by the facility	**X**
Obtaining Emergency Medical Care	**X**
Administration of Minor First Aid Procedures	**X**
Photos	**X**
AGREEMENT	
Services provided by Your Child's World Learning Center, Inc. for the below fee:	
($170.00 weekly fee) 10 hours of care per day	
PLUS Trips/Activity Fee (Determined per trip and parent will be notified in advance.)	
Breakfast, Lunch, PM Snack (Must complete CACFP form application)	*All meals must be eaten at school and cannot be taken off school site excluding trips.
Parent Agrees to the following:	
Monthly fees are due on the 1st of the service month regardless of the number of days attended or vacation. A $100.00 late fee is assessed after the 5th of the service month.	
If parent receives child care assistance, parent agrees to pay the total fees owed if CCIS, DHS, or any other funding agency fails to pay.	
Parent received the parent handbook and will review and adhere to all the information.	
Update Emergency Contact and Agreement every 6 months and whenever a change occurs.	
Inform the schools Adm. whenever changes occur and provide proof of change if necessary and when requested.	
Keep your child home if your child has any signs of illness and/or cannot complete regular daily activities for whatever reason.	
Update dental forms every 6 months	Update health assessment/report forms every 12 months
Drop off child at X **______________________AM**	**Pick up child by X** **_____________________________PM**
Ensure that no outside food is brought to school.	Label all items sent to school.
Call when child is absent.	If child is absent 2 or more days, provide a Dr. note prior to returning.
Parent's Full Signature: X ____ **Print Name: X** ____	
Parent Email Address: **X**	
Date: X _______________________	

Child and Adult Care Food Program

Sponsor/Center Name: Your Child's World Learning Center, Inc. **Agreement #:**300-51-002-7

ENROLLMENT FORM FOR SCHOOL AGE CHILDREN IN CHILD CARE

PARENTS: This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents and guardians to complete a CACFP Annual Enrollment Form when enrolling their child(ren) and again every year thereafter. This information will help ensure all children receive appropriate meals during their care.

Please complete all areas of the application.

		Days Child Normally Attends	Times child normally attends during the week	
First Name		❑ Monday	**AM**	**PM**
		❑ Tuesday		
Last Name		❑ Wednesday	**Times child attends school when school is in session**	
		❑ Thursday		
		❑ Friday	**AM**	**PM**
Birth Date				
Age				
	I work multiple shifts and child(ren) may be in care different days/hours	**Meals Expected to receive during care**		
	❑ Yes	❑ Breakfast		
	❑ No	❑ Lunch		
		❑ PM Snack		

____ ____________________

Signature of Parent/Guardian Date

CHILD CARE REPRESENTATIVE ONLY:

Enrollment Date		**Withdrawal Date**	

____ ____________________

Signature of Parent/Guardian Date

The effective date can be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month this form is received

The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800)877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

Child and Adult Care Food Program

Child Care Center Meal Benefit Income Eligibility Form

Part 1. All Household Members

Name of Enrolled Child(ren)

Names of all household members (First, Middle Initial, Last)	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.	CHECK IF NO INCOME
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Part 2. Benefits: If any member of your household received [State SNAP], [FDPIR], or [State TANF cash assistance], provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME:____ CASE NUMBER: ___ ___ - ___ ___ ___ ___ ___ ___ ___

Part 3. If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call **[Your center director, Homeless Liaison, Migrant Coordinator]** Homeless ❑ Migrant ❑ Runaway❑

Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List **only** household members with income)	**B. Gross income and how often it was received**			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) *Jane Smith*	$200/weekly	$150/twice a month	$100/monthly	$______/________
	$______/________	$______/________	$______/________	$______/________
	$______/________	$______/________	$______/________	$______/________
	$______/________	$______/________	$______/________	$______/________
	$______/________	$______/________	$______/________	$______/________
	$______/________	$______/________	$______/________	$______/________

Part 5. Signature and Last Four Digits of 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 the last four digits of 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: ____ Print Name: ____

Date: ____________________________

Address: ____ Phone Number: _______________________

City:____ State: ________________ Zip Code: ________________

Last four digits of Social Security Number: _*_ _*_ _*_ - _*_ _*_ - __ __ __ __ ❑ I do not have a Social Security Number

Part 6. 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 ❑ American Indian or Alaska Native ❑ White ❑ Native Hawaiian or Other Pacific Islander ❑ Black or African American

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: _____ Eligibility: Free_____ Reduced_____ Denied (Paid)_____ Date Withdrawn: ___________________

Reason for Denied:___ ____

Temporary: Free_____ Reduced_____ Time Period: ______________________________(expires after _____ days)

Determining Official's Signature: ____ Date: ______________

Confirming Official's Signature: ____ Date: ______________

Follow-up Official's Signature: ____ Date:______________

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	$21,590
2	$29,101
3	$36,612
4	$44,123
5	$51,634
6	$59,145
7	$66,656
8	$74,167
Each additional person:	+$7,511

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 the participant for free or reduced price meals. You must include the last four digits of 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 Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant 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 the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. "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 USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

Your Child's World Learning Center, Inc.

<u>School Information Form</u>

School Year: 2015-2016 ______ 2016-2017 ______2017-2018 ______ 2019-2020 ______

Child's Name: ____ **D.O.B:** _______________

☐ AM CARE ONLY	☐ PM CARE ONLY	☐ AM AND PM CARE

☐ M	☐ T	☐ W	☐ TH	☐ F

<u>*IF YOUR CHILD IS SCHEDULED FOR AM CARE AND DOES NOT ATTEND FOR AM CARE, WE WILL ASSUME THAT YOU WILL NOT NEED PM CARE UNLESS YOU CALL AND SPEAK TO LISA OR ELIZABETH.</u>

<u>*PLEASE CONTACT LISA OR ELIZABETH TO LET US KNOW IF YOUR CHILD NEEDS TO BE PICKED UP FROM SCHOOL IF YOU DID NOT DROP YOUR CHILD OFF TO THE CENTER IN THE MORNING. IT IS YOUR RESPONSIBILITY TO INFORM THE CENTER OF ALL CHANGES TO ENSURE THAT YOUR CHILD IS PICKED UP FROM SCHOOL.</u>

Parent's Name: ____

Parent's Phone Number (During School Hours) ____

School Name: ____

School Address: ____

Philadelphia, PA ______________________

School Start Time: _____________ **School End Time:** _____________

Teacher's Name: ____

Grade: ___________________________**Room Number:** ___________________________

Would you like us to begin your child's homework at the center? ☐ Yes ☐ No

<u>*Please talk to your child about your wishes for them to begin their homework at the center. Please note that your child may not complete their homework at the center due to other scheduled activities. We do not force children to do or complete their homework while in our program.</u>

Child Health Assessment

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN NAME:
DATE OF BIRTH:	PHONE:	ADDRESS:
CENTER NAME: Your Child's World Learning Center, Inc.		

PA child care providers must document that enrolled children have received age appropriate health services and immunizations that meet the current schedule of the American Academy of Pediatrics 141 Northwest Point Blvd., Elk Grove Village, IL 60007. The schedule is available at< www.aap.org> or Faxback 847/758-0391 (document #9535 and #9807)

Health history and medical information pertinent to routine child care and emergencies (describe, if any): DNONE	Date of most recent well-child exam:
Allergies to food or medicine (describe, if any): DNONE	Do not omit any information. This form may be updated by health professional. (Initial and date new data.) Child care facility needs 2 copies

LENGTH/HEIGHT	WEIGHT	BLOOD PRESSURE
________IN/CM %ILE _________	________LB/HG %ILE _________	(BEGINNING AT AGE 3)__________/ ____________

PHYSICAL EXAMINATION	☑☑=NORMA	IF ABNORMAL - COMMENTS
HEAD/EARS/EYES/NOSE/THROAT		
TEETH		
CARDIO/RESPIRATORY		
ABDOMEN/GI		
GENITALIA/BREASTS		
EXTREMITIES/JOINTS/BACK/CHEST		
SKIN/LYMPH NODES		
NEUROLOGIC & DEVELOPMENTAL		

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS (Complete Dates: Month, Day, Year)
DTaP/DTP/Td						
POLIO						
HIB						
HEP B						
MMR						
VARICELLA						
MENINGOCOCCAL						
PNEUMOCOCCAL						
INFLUENZA						
HEP A						
ROTAVIRUS						
OTHER/TB						

SCREENING TESTS	DATE TEST	☑☑=NORMA	IF ABNORMAL - COMMENTS
LEAD			
ANEMIA (HGB/HCT)			
URINALYSIS (UA at age 5)			
HEARING (subjective until age 4]			
VISION (subjective until age 3)			
PROFESSIONAL DENTAL EXAM			

HEALTH PROBLEMS OR SPECIAL NEEDS, RECOMMENDED TREATMENT/MEDICATIONS/SPECIAL CARE (ATTACH ADDITIONAL SHEETS IF NECESSARY)

NONE NEXT APPOINTMENT - MONTH/YEAR:

MEDICAL CARE PROVIDER:		SIGNATURE OF PHYSICIAN OR CRNP:	
ADDRESS:			
	PHONE:	LICENSE NUMBER:	DATE FORM SIGNED: