Chappaqua Children's Workshop

2022-23 School Year

Dear Parents,

Thank you for your interest in the CCW program. Please note that the Registration Application will only be accepted if filled out in its entirety. Your child can not be registered in CCW unless all forms are submitted with the application.

Please follow the checklist below:

- ❑ Registration Application
- ❑ Physical Form – pages 9-10
- ❑ Immunization Form
- ❑ Sign page 3 – Statement of Policy
- ❑ If medication is needed: Physician and parent/guardian MUST sign pages 7 – 8; Medication Consent form
- ❑ Calculate June tuition deposit (refer to brochure for rates)
- ❑ $100 Membership fee (per child)

Please mail all information to:

CCW
P.O. Box 918
Chappaqua, NY 10514

Our **last day of accepting registration** information will be **Monday, August 15** by 4pm. CCW has an **ENROLLMENT BLACK-OUT** beginning August 16, 2022. We will resume regular enrollment procedures on Monday, September 12th.

Sincerely,

Joanne Saporta

Joanne Saporta
Executive Director

2022-2023

CCW ELEMENTARY PROGRAMS - REGISTRATION APPLICATION

Child's Name: _____

Siblings in Program: _____

Address: _____City: _____Zip: _____

Sex: _____Date of Birth: _____Grade (2022-23): _____

School Attending: _____Teacher: _____Bus#: _____

Mother/Guardian	Father/Guardian
Name: _____	Name: _____
Address: _____	Address: _____
Home Phone: _____	Home Phone: _____
Name of Business: _____	Name of Business: _____
Work Phone: _____	Work Phone: _____
Cell Phone: _____	Cell Phone: _____
*E-Mail: _____	*E-Mail: _____

*** E-Mail address is for a distribution list for emergency notifications and messages.**

Check off program and circle days

_____ Before School (7:30 – school start time)

M T W TH F

_____ Afterschool (until 5:15 PM)

M T W TH F

_____ Afterschool (until 6:15 PM)

M T W TH F

_____ Drop-In (NO GUARANTEE – SPACE IS LIMITED)
*only a $100 membership fee is required

OFFICE USE ONLY FM____ QB_____ COPIED_____ MAILED_____

STATEMENT OF POLICY

For a child to be admitted to CCW, parents must complete the registration packet and sign the Policy Statement.

1. **ADMISSIONS:** CCW welcomes elementary school-age children from the Chappaqua School District without regard for race, gender, religion, creed, ethnic or national origin. CCW serves children from all three elementary schools – Roaring Brook, Grafflin and Westorchard schools. Special attention is given to each child's needs. CCW may request an initial interview with parent and child prior to placement in its program to determine if the child's needs can be met in its setting.

2. **TUITION AND FEES:** A non-refundable $100.00 membership fee and a one-month tuition deposit are required to secure a place for your child. *The tuition deposit is non-refundable and can only be applied to June tuition. Tuition deposits cannot be used as a credit for another month if a child changes his/her schedule.* No credit on tuition is given for sick days, school holidays, snow days or vacation days. No tuition refund is given for any changes in your child's monthly payment schedule unless we have two weeks notice. Tuition is due by the 1st of the preceding month. **A $25.00 LATE FEE WILL BE ASSESSED AFTER THE 15th.** If tuition payment becomes more than TWO months delinquent, your child will not be allowed to attend CCW until the payment is brought up to date. **Teachers my NOT accept tuition payments. Please mail to P.O. Box 918 Chappaqua or leave in the DROP-BOX at 113 King St. Chappaqua.** ***Please note that June's tuition is non-refundable, so select your days carefully.***

3. **WITHDRAWAL:** A child may be asked to withdraw from CCW if in the judgment of the professional staff, he or she is not able to function positively in our group setting, or CCW's program is not able to meet the special needs of that particular child.

4. **HEALTH CARE:** Our teachers may not administer medication of any kind to any child attending CCW unless the Medication Consent Form is signed by both a parent/guardian and physician, and is handed in with the medication (please see pages 7 and 8).

5. **CHILD ABUSE and MALTREATMENT:** CCW is mandated by the New York State Office of Children and Family Services to report any suspicion of child abuse or maltreatment. Reports will be submitted when any member of CCW's staff has reasonable cause to suspect that a child whom the reporter sees in *his/her professional capacity is abused or maltreated.*

6. **TRANSPORTATION:** Parents must assume responsibility for safe transportation of their child to and from CCW unless he/she is transported by the Chappaqua School Bus Company.

7. **COMMUNICATION WITH THE SCHOOL DISTRICT:** From time to time during the school year, it may be helpful for us to discuss your child's progress and development with his/her classroom teacher or school's professional staff. All information will be held in strictest confidence. We assure you that we will ALWAYS discuss this with you before contacting school personnel.

CHILD'S NAME: _____ CCW PROGRAM: _____

***PARENT/GUARDIAN SIGNATURE:** _____ ***DATE:** _____

EARLY DISMISSAL/MEDICAL EMERGENCY CONTACTS

Please fill out carefully and sign below. We **must** have two emergency names and phone numbers (other than the parents) on file. If they change, please notify us. Thank you.

CHILD'S NAME: _____ SCHOOL: _____

I hereby authorize, in the event my child is ill or in medical emergency that if **I cannot** be reached, the following individuals be contacted (please select someone locally who would be willing to come for your child in the event he/she becomes ill). Please provide only one number for each contact. If more than one number is provided, only the first number can be entered into the computer program.

1. Name: _____

   Home Address: _____

   Telephone Numbers: _____

2. Name: _____

   Home Address: _____

   Telephone Numbers: _____

I give my permission for CCW to seek **emergency** treatment for my child in the event that the above-designated individuals or I cannot be contacted immediately.

I hereby request, in the event of an emergency evacuation or early dismissal of the Chappaqua Schools, that my child be sent to: (please select a name of someone locally, possibly on the same bus route).

1. Name: _____

   Home Address: _____

   Telephone Numbers: _____

2. Name: _____

   Home Address: _____

   Telephone Numbers: _____

AUTHORIZATION FOR NON-PARENT PICK-UP

The following people are authorized to pick up my child: We cannot release your child to ANYONE without a signed, written consent.

1. Name: _____ Phone: _____
2. Name: _____ Phone: _____

Parent/Guardian signature: _____ Date: _____

CHILD/FAMILY HISTORY

Child's Name: _____ Physician's Name: _____
Physician's Address: _____ Phone: _____

Present Family Structure:
Parents: Married ____ Separated ____ (who does the child live with?) _____
Divorced ____ Parent Deceased _____ Single Parent ____
Child: Foster child_____ Adopted: _____ (optional)

List name, ages and any special relationship of other children in the family:
Name _____ Age _____ Relationship _____
Name _____ Age _____ Relationship _____
Name _____ Age _____ Relationship _____
Is there any other information you would like to share with us?
_____

In order to best meet the needs of each individual child, it would be helpful for you to share with us any information that will assist us in caring for your child. Please answer the following questions, feeling free to elaborate whenever necessary, so that we may be aware of your child's specific needs. Attach a separate sheet of paper if necessary. (PLEASE NOTE THAT ALL INFORMATION IS CONFIDENTIAL.)

Medical conditions: Please note any conditions which may affect your child and explain symptoms which may help us identify possible problems:

Food allergies/Special diets: _____
Symptoms: _____
Drug allergies: _____
Symptoms: _____
Insect or other allergies: _____
Symptoms : _____
Asthma : ___ Symptoms : _____ Diabetes : ___ Symptoms : _____
Seizures: ___ Symptoms: _____ A.D.D/Hyperactivity: ___ Symptoms:
_____

*** If your child is designated through the Committee on Special Education: check here____
(Please be assured that all information will be kept in strict confidence).

Medications: *_____
Are there any other health conditions for which your child is currently being treated for by a physician?
_____

Please list any other conditions or health problems of which we should be aware and include those that may limit your child's participation in activities:
_____

***If any medication is required, please read, complete, and sign release form on pages 7 – 8. You and your physician's signatures MUST complete the consent form.** *Medication cannot be administered without these forms on file. There can be no exceptions.*

CHILD/FAMILY HISTORY – Part 2

Individual Descriptions: Do you have special concerns for your child in any of the following areas? IF NOT, LEAVE BLANK.

___Socialization: (i.e. overly shy; does not play well with other children; does not separate easily from parent).
Comments:

___Behavior: (i.e. sometimes has difficulty following routines and/or accepting limits).
Comments:

___Speech/Language: (i.e. speech is sometimes unclear; has difficulty expressing needs; often requires instructions to be repeated).
Comments:

___Maintaining attention: (i.e. distracted easily; short attention span; darts from one task to another).
Comments:

___Large/Small motor abilities: (i.e., some difficulty with balance; hand/eye coordination problems).
Comments:

___Visual: (i.e. eye turn in/out; squints; spatial difficulties).
Comments:

___Hearing: (has difficulty hearing; asks you to repeat or talk louder; startles at sudden noise).
Comments:

What are your child's strengths?
_____
_____

Does your child have any fears or anxieties you would like us to know about?
_____

What is his/her temperament?
_____
_____

ADMINISTRATION OF MEDICATION

1. Written authorization by the child's parent or legal guardian and by a licensed physician, as well as detailed instructions for administration and use, must be on file for any student taking medication while in attendance at the program.

2. Written permission must also be on file if a child is to be permitted to use a medication such as an inhaler that he/she carries.

3. The "Administration of Medication Release Form" must be signed be the parent or legal guardian before any medication can be administered by CCW personnel.

4. A child's parent or legal guardian is responsible for providing and replenishing as necessary, products to be administered on an emergency basis for a known condition. An example of this would be an EPI-PEN (Epinephrine Auto-Injector) for allergic emergencies.

5. No child who requires the administration of medication may continue in attendance at CCW unless a current "Authorization Form" detailed instruction for administration of medication and a Release Form are on file. Similarly, a child's attendance will be suspended if a parent fails to make available or replenish as necessary his or her emergency medication. If a child's attendance is suspended for any of the foregoing reasons, a refund of tuition will not be provided.

ADMINISTRATION OF MEDICATION RELEASE FORM

(Please select either I or II)

The undersigned parent/legal guardian of _____hereby:
Child's name

I.

A. Acknowledges that I have **given permission** for the staff of the Chappaqua Children's Workshop Inc. (CCW) to administer medication to my child;

B. Acknowledges that CCW staff are NOT licensed medical professionals; and

C. Releases CCW, its officers, directors and employees from any and all liability or responsibility in connection with, or resulting from, the administration of medication to my child on a prescribed or emergency basis, except to the extent their actions are found to constitute gross negligence or willful misconduct.

_____ _____
Date Signature or Parent/Legal Guardian

II.

I **decline permission** for the staff of Chappaqua Children's Workshop Inc. (CCW) to administer medication to my child

_____ _____
Date Signature or Parent/Legal Guardian

LEAVE BLANK

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD IN CARE MEDICAL STATEMENT

To Be Completed By Licensed Physician, Physician Assistant or Nurse Practitioner

Name of Child:	Date of Birth: / /	Date of Examination: / /

Immunizations required for entry into day care

Medical Exemption The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s). ☐ Yes ☐ No

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	5th Date / /
Polio (IPV or OPV)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	
Haemophilus influenzae type B (Hib)	1st Date / /	2nd Date / /	3rd Date / /	4th Date **OR** 1st Date (if given on or after 15 months of age) / /	
Pnuemococcal Conjugate (PCV) for those born on or after 1/1/08)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	
Hepatitis B	1st Date / /	2nd Date / /	3rd Date / /		
Measles, Mumps and Rubella (MMR)	1st Date / /	2nd Date / /			
Varicella (also known as Chicken Pox)	1st Date / /	2nd Date / /			

Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

Type of Immunization:	Date: / /	Type of Immunization:	Date: / /
Type of Immunization:	Date: / /	Type of Immunization:	Date: / /
Type of Immunization:	Date: / /	Type of Immunization:	Date: / /

Tests

Tuberculin Test Date: / / Mantoux Results: ☐ Positive ☐ Negative _____ mm

TB Tests are at the physician's discretion. Acceptable tests include Mantoux or other federally approved test.

If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: / /

Attach lead level statement

Lead Screening (Include All Dates and Results)

1 year / / Result: _____ mcg/dL ☐ Venous ☐ Capillary

2 years / / Result: _____ mcg/dL ☐ Venous ☐ Capillary

Most recent date of lead screening (if different from above):

/ / Result: _____ mcg/dL ☐ Venous ☐ Capillary

Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely. If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.

(Continued on reverse side)

CHILD IN CARE MEDICAL STATEMENT *(continued)*

Health Specifics		Comments
Are there allergies? (Specify)	☐ Yes ☐ No	
Is medication regularly taken? (Specify drug and condition)	☐ Yes ☐ No	
Is a special diet required? (Specify diet and condition)	☐ Yes ☐ No	
Are there any hearing, visual or dental conditions requiring special attention?	☐ Yes ☐ No	
Are there any medical or developmental conditions requiring special attention?	☐ Yes ☐ No	

Summary of Physical Exam

Include special recommendations to child day care providers

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in child day care. ☐ Yes ☐ No

Signature of Examiner

Address

Please Print Name

City, State, Zip

Title

( ) - Phone

/ / Date