# Chappaqua Children's Workshop

2021-2022 School Year

Dear Parents,

Thank you for your interest in the CCW/KU programs. Please note that the Registration Application will only be accepted if filled out in its entirety. Your child can not be registered in CCW/KU 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 page 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/KU
P.O. Box 918
Chappaqua, NY 10514

Our **last day of accepting registration** information will be **Monday, August 16th** by 4pm. CCW/KU has an **ENROLLMENT BLACK-OUT** beginning August 16, 2021. We will resume regular enrollment procedures on Sept 13th.

Sincerely,
*Joanne Saporta*

Joanne Saporta
Executive Director

**2021-2022**

**KIDS UNLIMITED - REGISTRATION APPLICATION**

Child's Name: _____

Siblings in Program: _____

Address: _____City: _____Zip: _____

Sex: _____Date of Birth: _____Grade (entering 2021-2022): _____

School Attending: _____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**

_____ Afterschool (until 5:00 PM)

M T W TH F

_____ Afterschool (until 6:00 PM)

M T W TH F

_____ Drop-In and Focus on Fun
*only a $100 membership fee is required

FOR OFFICE USE ONLY: FM____ QB_____ COPIED_____ MAILED_____

# STATEMENT OF POLICY

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

1. **ADMISSIONS:** KU welcomes middle school-age children from the Chappaqua School District without regard for race, gender, religion, creed, ethnic or national origin. KU serves children from both Robert E. Bell and Seven Bridges Middle Schools. Special attention is given to each child's needs.

**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 KU 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 KU if in the judgment of the professional staff, he or she is not able to function positively in our group setting, or KU'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 KU 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**: KU 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 KU'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 KU 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: _____

**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?
_____
_____

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

# MEDICATION CONSENT FORM
# CHILD DAY CARE PROGRAMS

- This form may be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays.
- Only those staff certified to administer medications to day care children are permitted to do so.
- One form must be completed for each medication. Multiple medications cannot be listed on one form.
- Consent forms must be reauthorized at least once every six months for children under 5 years of age and at least once every 12 months for children 5 years of age and older.

**LICENSED AUTHORIZED PRESCRIBER COMPLETE THIS SECTION (#1 - #18) AND AS NEEDED (#33 - 35).**

| 1. Child's First and Last Name: | 2. Date of Birth: / / | 3. Child's Known Allergies: |
|---|---|---|
| 4. Name of Medication *(including strength):* | 5. Amount/Dosage to be Given: | 6. Route of Administration: |

7A. Frequency to be administered: _____

***OR***

7B. Identify the symptoms that will necessitate administration of medication: *(signs and symptoms must be observable and, when possible, measurable parameters)*: _____

8A. Possible side effects: ☐ See package insert for complete list of possible side effects *(parent must supply)*

***AND/OR***

8B: Additional side effects:

9. What action should the child care provider take if side effects are noted:

☐ Contact parent ☐ Contact health care provider at phone number provided below

☐ Other *(describe):* _____

10A. Special instructions: ☐ See package insert for complete list of special instructions *(parent must supply)*

***AND/OR***

10B. Additional special instructions: *(Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situation's when medication should not be administered.)* _____

11. Reason for medication *(unless confidential by law)*: _____

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and requires health and related services of a type or amount beyond that required by children generally?

☐ No ☐ Yes If you checked yes, complete (#33 and #35) on the back of this form.

13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered?

☐ No ☐ Yes If you checked yes, complete (#34 -#35) on the back of this form.

| 14. Date Health Care Provider Authorized: / / | 15. Date to be Discontinued or Length of Time in Days to be Given: / / |
|---|---|
| 16. Licensed Authorized Prescriber's Name (please print): | 17. Licensed Authorized Prescriber's Telephone Number: |

18. Licensed Authorized Prescriber's Signature:

**X**

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

# MEDICATION CONSENT FORM
# CHILD DAY CARE PROGRAMS

## PARENT COMPLETE THIS SECTION (#19 - #23)

19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? *(For example, did the licensed authorized prescriber write 12pm?)* ☐ Yes ☐ N/A ☐ No

Write the specific time(s) the child day care program is to administer the medication *(i.e.: 12 pm*): _____

20. I, parent, authorize the day care program to administer the medication, as specified on the front of this form, to *(child's name):*

| 21. Parent's Name *(please print)*: | 22. Date Authorized: / / |
|---|---|

23. Parent's Signature:

**X**

## CHILD DAY CARE PROGRAM COMPLETE THIS SECTION (#24 - #30)

| 24. Program Name: | 25. Facility ID Number: | 26. Program Telephone Number: |
|---|---|---|

27. I have verified that (#1 - #23) and if applicable,(#33 - #36) are complete. My signature indicates that all information needed to give this medication has been given to the day care program.

| 28. Staff's Name *(please print)*: | 29. Date Received from Parent: / / |
|---|---|

30. Staff Signature:

**X**

## ONLY COMPLETE THIS SECTION (#31 - #32) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN (#15)

31. I, parent, request that the medication indicated on this consent form be discontinued on / / _____
(Date)

Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.

32. Parent Signature:

**X**

## LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #35)

33. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.

34. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date you are ordering the change in the administration of the prescription to take place.

DATE: / / _____

By completing this section, the day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.

35. Licensed Authorized Prescriber's Signature:

**X**

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# 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.

## 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