childdevelopmentcenter
at kingsborough community college

Registration Packet

(Current Parents)

Hello,

Welcome back to another semester at the Child Development Center! We are so happy to see you and your child(ren) once again!

This packet is similar to the first one that you filled out when you first enrolled your child, with some exceptions. We update our files every semester. To keep your child's information up to date, we are asking that you fill out this packet and return it before the end of the registration deadline to reserve your spot.

There is a required deposit of $20 to keep your child enrolled for the upcoming semester. This deposit must be paid when you are submitting this packet.

We are excited that you're back with us! Thanks for choosing the Child Development Center at Kingsborough once again!

childdevelopmentcenter
at kingsborough community college
2001 Oriental Boulevard, Room V-105, Brooklyn, NY 11235 Telephone: 718.368.5868

Policy Statement & Enrollment Agreement

Welcome! We are happy that you have selected the Child Development Center for your child's first learning experience. We are here to provide a safe and nurturing environment for your child while you focus on your studies.

The following agreement is between the Child Development Center ("the Center") and the parent/legal guardian of _____. I agree to the following:

Processing Fee/Registration Information

As a first time registrant, I agree to pay a one-time, non-refundable processing fee of $10. Additionally, I will pay a non-refundable deposit of $20 prior to registration each semester, to be paid upon registration of my child. If I need to with draw your child before the end of the semester, **I agree to notify the Center in writing by completing an Exit Form**. Withdrawal from the Center will change my child's priority. If I am interested at returning to the Center in the future, I understand that I will need to reapply to the center through the waiting list.

Payments/Financial Information

I understand that I am required to make payments on time. Payment plans can be arranged if needed. Failure to make payments may result in interruption of child care services. I agree to provide the Center with the academic and financial information necessary to determine my eligibility for childcare services. I also agree to notify the center of any changes relevant to my eligibility for child care services.

Authorized Escorts/Emergency Information

I agree to:

1) supply a locally available person, on the yellow emergency form, who is ready and willing to pick up my child in the event that I cannot be reached;

2) provide complete medical records for my child prior to admission;

3) allow for emergency medical treatment to be given to my child in the case of an accident or injury, in the case that I cannot be reached immediately;

4) to give the center a printed copy of my class schedule from CUNYfirst whenever my child is in the Center;
5) to provide the Center with the name, address and telephone number where I can be reached, whenever I am on field assignment (hospital, school, clinic, etc.);

6) to inform the Center of any classroom changes or schedule changes, such as adding or dropping a class, by filling out a **schedule change form**.

I understand that my child will not be released to any person other than the registered parents, unless written authorization and a photo is submitted. I agree to notify the center staff by a phone or my child's teacher in person or in writing whenever an authorized person is picking my child up. I also understand that the authorized pick up must provide valid photo identification when picking up my child, with **no exceptions**.

I have read, understood, and by signing below , affirm my agreement with the above policy statements.

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

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Brooklyn, NY 11235
718.368.5868

Allergy/Medical Needs

Child's Name:

Child's Birthdate:

Semester & Year:

Please list all allergies — food and otherwise — that your child has:

Please list any foods your child may not have due to religious or other observances:

Please list any medical needs your child has. Please include any important information the center needs to know and/or do for your child:

Parent's Signature: _____ **Today's Date:** _____

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Meal Choice Form

The Child Development Center participates in the Child and Adult Care Food Program, also known as CACFP. To ensure that we, as well as our vendor, Green Top Farms, are providing meals that meet your child's needs, please take a moment to review the meal types that we serve at the center:

Classic - regular meals that contain well-balanced, healthy foods from all food groups

Vegetarian - meatless meals that contain well-balanced, healthy food choices

Egg/Dairy Free - egg and dairy free meals that contain well-balanced, healthy food choices

Specialized - other options, such as soy-free, gluten-free, tomato-free, tofu-free, etc.

Please select the type of meals you would like for your child to receive: - select one -

If you chose specialized, please indicate your meal preference:

_____ **Child's Name**

_____ **Today's Date**

_____ **Parent/Guardian's Name**

_____ **Parent/Guardian's Signature**

Note: If your child's dietary needs change at any time, **please inform the center immediately**.
We will gladly inform our food vendor so your child can receive the correct meal.
You must complete and sign a new form to make any dietary changes.

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Authorized Escort Form

Child's Name: _____ **Parent/Guardian's Name:** _____

Parent/Guardian's Email Address: _____

Cell Phone No.: _____ **Child's Classroom:** _____

Authorized Escort Information:

Escort Name:_____ **Relationship to Child:** _____ **Cell Phone:**_____

Please provide your initials next to the frequency with which the authorized escort is allowed to pick your child up:

_____ **Anytime** - ***My child can be picked up by the authorized escort at any time.***

_____ **Weekly** - ***The authorized escort can only pick my child up on the days specified below:***

☐ **Monday** ☐ **Tuesday** ☐ **Wednesday** ☐ **Thursday** ☐ **Friday** ☐ **Saturday**

_____ **Once in a While** - ***The authorized escort will be picking up my child occasionally.***
**On these days, I will inform my child's teacher and write all pick up in the classroom's Parent Log Book*
In the event that I fail to inform the Center staff and provide pick up information, I understand that the center will contact me using the contact information provided above.

***If I am unable to pick my child up due to illness, injury or unforeseen emergency*, I give permission for the center to contact the above authorized escort to pick up my child (please initial next to your choice):**

_____ **Yes, I give my permission.** _____ **No, I do not give my permission.**

By signing this document, I affirm the following:

1) **I give permission for the adult specified to be an authorized escort for my child;**
2) **The authorized escort in this document is aged 18 or older;**
3) **I must notify the center and my child's teacher before the selected authorized escort picks up my child for the first time;**
4) **The selected authorized escort must show valid identification and arrive on time for pick up;**
5) **If I choose to add a new authorized escort or remove an existing authorized escort, I must notify the center in writing (in the case of adding an authorized escort, I must complete a new Authorized Escort form.)**

Parent Signature: _____ **Today's Date:** _____

Class: _____

Semester Started: _____

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Emergency Contacts

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

Home Address: _____ **Phone:** _____

(List Student/Parent First)

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

Physician: _____ **Phone:** _____

Food Allergies: _____ **Other Allergies:** _____

Medications: _____ **Hospital:** _____

Other Significant Information: _____

Curriculum Major: _____

I give permission to the Child Development Center of Kingsborough Community College to make whatever emergency measures as judged necessary for the care and protection of my child, while under the center's supervision.

In the case of a medical emergency, I understand that they will be transported to an appropriate medical facility by the local emergency unit for treatment if the local emergency resource deems it necessary

It is understood that in some medical situations, the staff will need to contact the emergency resource before the physician.

Date: _____ **Signature:** _____

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly

NYC ID (OSIS)

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name | **First Name** | **Middle Name** | **Sex** ☐ Female ☐ Male | **Date of Birth** *(Month/Day/Year)* ___ ___ / ___ ___ / ___ ___ ___ ___

Child's Address | **Hispanic/Latino?** ☐ Yes ☐ No | **Race** *(Check ALL that apply)* ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other _____

City/Borough | **State** | **Zip Code** | **School/Center/Camp Name** | **District** __ __ **Number** __ __ __

Phone Numbers Home _____ Cell _____ Work _____

Health insurance (including Medicaid)? ☐ Yes ☐ No

☐ **Parent/Guardian** ☐ **Foster Parent** **Last Name** **First Name** **Email**

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* _____

☐ Foods *(list)* _____

☐ Other *(list)* _____

Attach MAF if in-school medications needed

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma ***(check severity and attach MAF)***: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None

Asthma Control Status ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis
☐ Behavioral/mental health disorder
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes ***(attach MAF)***
☐ Orthopedic injury/disability
Explain all checked items above.

☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) _____
☐ ***Addendum attached.***

Medications ***(attach MAF if in-school medication needed)***

☐ None ☐ Yes *(list below)*

_____
_____
_____
_____

PHYSICAL EXAM **Date of Exam:** ___ /___ /___

Height _____ **cm** (___ ___ %ile)

Weight _____ **kg** (___ ___ %ile)

BMI _____ **kg/m²** (___ ___ %ile)

Head Circumference *(age ≤2 yrs)* _____ **cm** (___ ___ %ile)

Blood Pressure *(age ≥3 yrs)* _____ / _____

General Appearance:

☐ Physical Exam WNL

Nl Abnl	*Nl Abnl*	*Nl Abnl*	*Nl Abnl*	*Nl Abnl*
☐ ☐ Psychosocial Development	☐ ☐ HEENT	☐ ☐ Lymph nodes	☐ ☐ Abdomen	☐ ☐ Skin
☐ ☐ Language	☐ ☐ Dental	☐ ☐ Lungs	☐ ☐ Genitourinary	☐ ☐ Neurological
☐ ☐ Behavioral	☐ ☐ Neck	☐ ☐ Cardiovascular	☐ ☐ Extremities	☐ ☐ Back/spine

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)*

Validated Screening Tool Used? ☐ Yes ☐ No

Date Screened ___/___/___

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help
☐ Communication/Language ☐ Gross Motor/Fine Motor
☐ Social-Emotional or Personal-Social ☐ Other Area of Concern: _____

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< 1 year ☐ Breastfed ☐ Formula ☐ Both

≥ 1 year ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred

Dietary Restrictions ☐ None ☐ Yes *(list below)*

SCREENING TESTS	*Date Done*	*Results*
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	___/___/___	_____ µg/dL
	___/___/___	_____ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	___/___/___	☐ At risk *(do BLL)* ☐ Not at risk
—— Child Care Only ——		
Hemoglobin or Hematocrit	___/___/___	_____ g/dL _____ %

Hearing	*Date Done*	*Results*
< 4 years: gross hearing	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*
OAE	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*
≥ 4 yrs: pure tone audiometry	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*

Vision	*Date Done*	*Results*
<3 years: Vision appears:	___/___/___	☐ *Nl* ☐ *Abnl*
Acuity (required for new entrants and children age 3-7 years)	___/___/___	Right _____ /_____ Left _____ /_____ ☐ Unable to test
Screened with Glasses?		☐ Yes ☐ No
Strabismus?		☐ Yes ☐ No

Dental

Visible Tooth Decay	☐ Yes ☐ No
Urgent need for dental referral *(pain, swelling, infection)*	☐ Yes ☐ No
Dental Visit within the past 12 months	☐ Yes ☐ No

CIR Number

Physician Confirmed History of Varicella Infection ☐

Report only positive immunity:

IMMUNIZATIONS – DATES

DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___

Tdap	___/___/___	___/___/___	___/___/___						
MMR	___/___/___	___/___/___	___/___/___						
Varicella	___/___/___	___/___/___	___/___/___						
Mening ACWY	___/___/___	___/___/___	___/___/___						
Hep A	___/___/___	___/___/___	___/___/___						
Rotavirus	___/___/___	___/___/___	___/___/___						
Mening B	___/___/___	___/___/___	___/___/___						
Other _____	___/___/___	_____	___/___/___						

IgG Titers	Date
Hepatitis B	___/___/___
Measles	___/___/___
Mumps	___/___/___
Rubella	___/___/___
Varicella	___/___/___
Polio 1	___/___/___
Polio 2	___/___/___
Polio 3	___/___/___

ASSESSMENT ☐ **Well Child** (Z00.129) ☐ **Diagnoses/Problems** *(list)* **ICD-10 Code**

_____ _____
_____ _____
_____ _____

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions (*specify*) _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: __ __/__ __/__ __

Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision

☐ Other _____

Health Care Practitioner Signature | Date Form Completed ___/___/___

Health Care Practitioner Name and Degree *(print)* | Practitioner License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone | Fax | Email

DOHMH ONLY **PRACTITIONER I.D.**

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments:

Date Reviewed: ___/___/___ **I.D. NUMBER**

REVIEWER:

FORM ID#

NEW YORK STATE DEPARTMENT OF HEALTH
Child and Adult Care Food Program

Income Eligibility Form
for Child Care Centers

See INSTRUCTIONS on reverse.

CHILD CARE CENTER NAME **Child Development Center at Kingsborough Community College**

Print the name of the child(ren) enrolled in this child care center

1. _____ 2. _____ 3. _____

DIRECTIONS

Complete SECTION A if anyone in your household
1. Participates in the Supplemental Nutrition Assistance Program (SNAP)
2. Receives Temporary Assistance to Needy Families (TANF)
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR) OR
4. Is a foster child

SECTION A

SNAP Case # _____

TANF # _____

FDPIR # _____

Names of Foster Children _____

_____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true. I understand that the center will get Federal funds based on the information I give.

Signature _____

Date _____

FOR SPONSOR USE ONLY

CACFP Agreement # _____

Total Number of Household Members _____
(INCLUDING FOSTER CHILDREN, IF APPLICABLE)

Total Household Income $ _____

Free _____ Reduced _____ Paid _____

Date of Determination _____

Signature of Center Staff _____

Complete SECTION B if no one in your household participates in SNAP, receives TANF, participates in FDPIR or if none of the children enrolled in the child care center is a foster child.

SECTION B

List all household members below. Include yourself and all adults and children NOT listed above, even if they do not receive income. Then list all income received **last month** in your household in the column to the right. Gross income includes: earnings from work, pensions, retirement, Social Security, child support, foster child's personal income and any other sources of income.

HOUSEHOLD MEMBER NAME	MONTHLY GROSS SALARY
1. _____	$ _____
2. _____	$ _____
3. _____	$ _____
4. _____	$ _____
5. _____	$ _____
6. _____	$ _____
7. _____	$ _____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true and that all income is reported. I understand that the center will get Federal funds based on the information I give.

Signature _____

Print Name _____

LAST FOUR (4) DIGITS OF SOCIAL SECURITY NUMBER ☐☐☐☐

DATE _____

USDA is an equal opportunity provider and employer.

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this form. 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 form. The Social Security Number is not required when you: apply on behalf of a foster child; provide a SNAP, TANF or FDPIR number; or when you indicate that the adult household member signing the form does not have a Social Security Number. We will use your information to determine if the center is eligible for free or reduced-price meal reimbursement and for administration and enforcement of the Program.

INSTRUCTIONS FOR COMPLETING DOH-3688

Definition of Income

Income means income before deductions for income taxes, social security taxes, insurance premiums, charitable contributions, and bonds, etc. It includes the following: (1) monetary compensation for services, including wages, salary, commissions or fees; (2) net income from non-farm self-employment; (3) net income from farm self-employment; (4) Social Security payments; (5) dividends or interest on savings or bonds, income from estates or trusts or net rental income; (6) unemployment compensation; (7) government civilian employee or military retirement, or pensions or veteran's payments; (8) private pensions or annuities; (9) alimony or child support payments; (10) regular contributions from persons not living in the household; (11) net royalties; (12) military benefits received in cash, such as housing allowance except if you are in the Military Housing Privatization Initiative; and (13) any other cash income.

Definition of Household

Household means *family* as defined in Section 226.2. *Family* means a group of related or non-related individuals who are not residents of an institution or boarding house, but who are living as one economic unit.

INSTRUCTIONS FOR PARENTS OR GUARDIANS

Write in the name of the child care center in the space provided.

Print the name of each child in your household who attends this child care center.

Section A: If anyone in your household participates in the Supplemental Nutrition Assistance Program (SNAP), receives Temporary Assistance for Needy Families (TANF) or participates in the Food Distribution Program on Indian Reservations (FDPIR), complete Section A only. Write down the SNAP, TANF or FDPIR number (do not use your ACS or DSS child care subsidy number). Then sign and date the form and return it to the day care center.

Foster children: If your household includes a foster child who is in child care, write in the names of the foster children.

Section B: Complete this section if you did not complete Section A. Write in your name and the names of all other adults and children living in the household, including unrelated people, even if they do not have any income. Do not include the children in child care who are listed at the top of the form.

Enter the amount of income each person received **last month**, before taxes or anything else was taken out. Refer to the Definition of Income and the Definition of Household, above. If any amount last month was more or less than the usual, write in that person's usual income.

The last four digits of the Social Security Number of the adult signing the certification is required. If you do not have a Social Security Number, write *none*. The form must be signed by an adult member of the household.

INSTRUCTIONS FOR CENTERS AND SPONSORS

The *For Sponsor Use Only* section is to be completed, signed and dated by center or sponsor staff. The sponsor/center representative must review the income eligibility form and ensure that it is completed as indicated in the instructions above. Then indicate the following:

The CACFP Agreement Number.

Total Number of Household Members – This item does not have to be completed if the parent completed Section A. Add those indicated in Section B (if completed) to the children enrolled in child care and the number of foster children, if applicable.

Total Household Income – This item does not need to be completed if the parent completed Section A. Indicate the total monthly income as calculated from Section B. If the parent chooses not to disclose income, the form must be categorized as *paid.*

Number of Free, Reduced or Paid – Compare the total household income and the total number of household members with the current year's Income Eligibility Guidelines (CACFP-3687) to determine if the household should be categorized as **Free, Reduced** or **Paid**. Use the appropriate column on the CACFP-3687 to categorize their income. For example, if the parent indicated biweekly income, multiply this amount by 26 to determine yearly income.

Incomplete forms (missing signatures, income information, last four digits of Social Security Number or SNAP, TANF or FDPIR numbers) are categorized in the paid category.

The income eligibility form is valid until the last day of the month one calendar year from the date it is signed by the household member. For example, a form signed on May 12, 2014 is valid until May 31, 2015.

APPLICATION FOR CHILD CARE SUBSIDY

SECTION #1

Name _____ **Student ID Number** _____

Residence Address _____ City _____, NY Zip Code _____

Mailing Address (if different) _____ City_____, NY Zip Code _____

Telephone Number_____ other phone numbers where you can be reached _____ Marital Status_____

SECTION #2

List everyone who lives with you even if they are not applying. List yourself first.

	First Name	M I	Last Name	Date of Birth	Social Security Number (SSN)	Sex M F, or X	Does this child need child care? Yes	No	Relation-ship to you	Hispanic or Latino? Yes	No	Enter Y (Yes) or N (No) for each race* I	A	B	P	W
1									SELF							
2																
3																
4																
5																
6																
7																
8																

***** Race/Ethnic Codes: **I** – Native American or Alaskan Native, **A** – Asian, **B** – Black or African American, **P** – Native Hawaiian or Pacific Islander, **W** - White

Please list maiden or other names by which you or anyone in your household has been known	First Name	M I	Last Name

Are you currently receiving or applying for other Child Care funding? Yes ☐ No ☐ f yes, name of agency: _____

You may use the back page if you need more room or there is other information that you think we might need

List names of everyone under 21 who are living in the household and write the absent parent's name and address.

Name of Person Under 21	Absent Parent's Name and Address

SECTION #3:

Are you currently in an undergraduate 2 year ☐ or 4 year ☐ program at CUNY? Yes ☐ No ☐ If yes which College? _____

Check the days and list the hours you need care:

❒ Monday_____ ❒ Tuesday_____ ❒ Wednesday_____ ❒Thursday_____ ❒ Friday_____

❒ Saturday_____ ❒ Sunday_____

Attach an official copy of class schedule

INCOME - ANSWER ALL QUESTIONS LISTED BELOW					
Indicate if you or anyone applying with you receives money from:	Yes	No	Gross Amount	Period (e.g., week, month, etc)	Who Receives?
Employment/self-employment including overtime, commissions, training programs, tips	☐	☐			
Child Support Payments (received)	☐	☐			
Alimony/Support (received)	☐	☐			
Unemployment Insurance Benefits	☐	☐			
Social Security Benefits (including SSI)	☐	☐			
Disability Benefits (NYS, VA, Private)	☐	☐			
Rental/ Boarders/Lodgers Income (received)	☐	☐			
Other (please specify)	☐	☐			
Office Use Only					

SECTION #4

READ THE IMPORTANT INFORMATION BELOW AND SIGN AT THE BOTTOM

PENALTIES – Your application may be investigated. By signing this agreement you are consenting to cooperate in such investigation. Federal and State laws provide for penalties of fine, imprisonment or both if you do not tell the truth when you apply for Child Care Assistance, at any time when you are questioned about your eligibility, or if you cause someone else not to tell the truth regarding your application or continuing eligibility. Penalties also apply if you conceal or fail to disclose facts regarding your initial or continuing eligibility for Child Care Assistance; or if you conceal or fail to disclose facts that would affect the right of someone for whom you have applied to obtain or continue to receive Child Care Assistance and such Child Care Assistance must be used for the other person and not yourself. It is unlawful to obtain Child Care Assistance by concealing information or providing false information.

CHANGES – I agree to inform the agency **promptly** of any change in my needs, income, living arrangement or address to the best of my knowledge or belief.
I agree to inform the agency promptly of any change in child care arrangements, including where child care is provided, who is providing care, provider's fees, and hours for which child care is needed.

CONSENT – I understand that by signing this application form, I agree to any investigation made by the Department of Social Services to verify or confirm the information I have given or any other investigation made by them in connection with my request for Child Care Assistance. If additional information is requested, I will provide it.

NON-DISCRIMINATION NOTICE – This application will be considered without regard to race, color, sex, disability, religious creed, national origin or political belief.

CERTIFICATION OF CITIZENSHIP/ALIEN STATUS FOR CHILD CARE ASSISTANCE - I hereby certify, under penalty of perjury, that all the children in need of Child Care Assistance _____

(list the names of all the child(ren) that are in need of child care assistance)

are United States (U.S.) citizens or nationals or persons with satisfactory immigration status. I understand that this information about these children may be submitted to the Immigration and Naturalization Service (INS) for verification of immigration status, if applicable. I further understand that the use or disclosure of this information about these children is restricted to persons and organizations directly connected with the verification of immigration status and the administration or enforcement of provisions of the Child Care Assistance program.

Signature_____ Date_____

CERTIFICATION: **I swear and/or affirm under the penalties of perjury that all of the information I have given or will give to the local Department of Social Services relating to Child Care Assistance is correct.**

APPLICANT/REPRESENTATIVE SIGNATURE	DATE SIGNED	HUSBAND/WIFE SIGNATURE	DATE SIGNED

Use this area for additional information:

I CONSENT TO WITHDRAW MY APPLICATION. I understand I may reapply at any time.

SIGNATURE _____

DATE _____

For Office Use Only

Applicant

Yes No

Applicant Enrolled in Cont. Education or BEOC
Applicant is Graduate student
Child is enrolled in Full day UPK program (UPK hours of care not eligible for FBG)
Child is enrolled in Half/day UPK program (UPK hours of care not eligible for FBG)
Child receives ACS/Early Start/ Head Start funding
Applicant is Faculty/Staff or community families

(Yes to any of the above applicant is not eligible)

Eligibility Determined by _____ Date _____

Eligibility Approved by _____ Date _____

Child Care Authorization Period: From _____ To_____

Comments:

_____
_____
_____

childdevelopmentcenter
at kingsborough community college

2001 Oriental Boulevard, Room V-105, Brooklyn, NY 11235
Telephone: 718.368.5868

Photo/Video Release Form

Occasionally, Kingsborough Community College staff and students may take photos and/or video the children at the Child Development Center at Kingsborough Community College. The photos or videos taken will be used for assignments in undergraduate classes at Kingsborough, or in marketing material for the college, and will not be used for any other purpose.

_____ I give my permission for my child be photographed/videotaped

_____ I do NOT give my permission for my child to be photgraphed/videotaped.

Child's Name:

_____

Parent/Guardian Name:

_____

Parent/Guardian Signature:

_____

Today's Date:

_____

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On-Campus Trip Permission Form

As part of your child's class curriculum, your child may participate in on-campus trips. These trips include walking trips and visits to on-campus facilities, such as the Performing Arts Center, MAC Theater or Student Union Center.

_____ I give my permission for my child to attend on-campus trips.

_____ I do **NOT** give my permission for my child to attend on-campus trips.

Child's Name:

_____

Parent/Guardian Name:

_____

Parent/Guardian Signature:

_____

Today's Date:

_____

Phone Number(s) where you can be reached on trip days:

_____

_____

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Parking Request Form

The Child Development Center at Kingsborough Community College receives an allotment of On-Campus Parking Permits each semester. If you are interested in applying for a permit, please complete this form:

Are you a Matriculating Student (actively taking classes?) ◯ Yes ◯ No

Are you a current KBCC student with a current CUNYfirst class schedule? ◯ Yes ◯ No

Will you be the driver of the car? ◯ Yes ◯ No

Child's Name: _____ **Parent/Guardian's Name:** _____

Model, Make & Year of Car:
(*ex.: 2021 Subaru Crosstrek*) _____

License Plate No.: _____

Semester:
(*ex.: Fall 2020*) _____ **Today's Date:** _____

Students will receive their parking permits before the semester begins, at the Parent Meeting. Parents who attend the Parent Meeting will have priority for any available permits. Completion of this form DOES NOT GUARANTEE an On-Campus Parking Permit.

Please Note: The On-Campus Parking fee is the same as the Student Parking fee.