Thresholds Mothers' Project Early Learning Center

Enrollment Application

Child's Name____

Gender____________________ Date of Birth____________________

Date of Enrollment___________________

Parent's Name_________________________ Co-Parent's Name_______________________

Address____

Phone Number____

Preferred contact method:

Phone call Text Either

Alternative phone number:______________________

Email: ____

Drop-off Time _______________________Pick-up Time______________________________

Current Work/School____

Work/School Address______________________________ Phone Number _______________

Child's Physician Name____

Physician Address_________________________________ Phone Number _______________

What are your hopes for your child in this program?

____

____

What concerns do you have about your child being in this program? ______________________

____

Do you have any special requests for your child?

____

____

Emergency Safety Plan

Emergency Contacts / Authorized Pick-Up People

1. Name ______________________ Relationship ______________________

   Phone Number ______________ Address ______________________

2. Name ______________________ Relationship ______________________

   Phone Number ______________ Address ______________________

3. Name ______________________ Relationship ______________________

   Phone Number ______________ Address ______________________

I understand that there are times when a crisis may come up that may make it difficult to take care of my child safely and that I have the obligation to create a safety plan for my child. The people identified on this safety plan are to care for my child in such crisis.

Parent Signature: ______________________________ **Date:** ________________

Early Learning Center Contact Information

Caroline Greco, Center Director: 773 537-3393 Cell: 872 239-6657

Infant Room: 773 537-3137

Toddler Room: 773 537-3139

Pre-K Room: 773 537-3138

Mother's Project Early Learning Center

Parent/Center Agreement

The following agreement has been developed to fulfill funding, licensing, and program requirements. Please initial each item to indicate that you agree and verify that you have read the policy.

In case of emergency, I give permission to the center staff to secure the needed emergency medical care if parent/guardian cannot be immediately contacted_______.

In the event that I cannot be contacted, the center staff may contact my emergency contacts listed in my safety plan to secure care for my child______.

My child may participate in all health related screenings, including vision and hearing_______.

Any picture taken of my child may be used in newspapers, displays, bulletin boards, or for publicity purposes _______.

My child may accompany his/her class on all visits, trips, neighborhood walks or excursions off learning center premises, including public transportation, facility vehicle transportation, and Thresholds approved personal vehicles_________.

My child will be in attendance in the program every day. If my child is sick, I agree to contact the center on the days of his/her absence. I understand that it is my responsibility to bring in a doctor's clearance for my child to return to the center if he/she has a contagious illness________.

I am welcome at the center anytime and agree to refrain from using inappropriate language or behavior while in the center. I understand that I can request and arrange for a parent conference and will be available for formal parent/teacher conferences________.

I will cooperate with the center in all areas including communicating with the teachers regularly, being available for formal and informal meetings, offering suggestions to enhance our program, volunteering on field trips and events when available, and to attend parent meetings________.

I will respond in a timely manner to all notices sent to me by the center including redeterminations, program fees, medical and dental exams. These are required by the funding

and licensing agencies, I understand my children may be terminated if I fail to respond ________.

I will provide the center with the information that is true and correct and inform the center when any information changes (i.e., changes in employment, income, phone numbers, address, emergency information, and authorized pickups) ________.

My child may be released only to the person(s) designated on my safety plan. If there is a change in pick-up, I will contact the center immediately to make them aware of who will be picking up the child. The authorized pick-up persons(s) are 13 years of age or older and must present identification________.

I understand that I must adhere to all of the rules and regulations stated above and that my child(ren) may be terminated if these rules are not followed_______.

Parent signature: ____________________________ Date:________________

Social Developmental History

Physical Health:

Is your child experiencing health problems or allergies (to medications, chemicals, food, or insects)? Yes______ No______Please describe.

____

____

____.

Does your child have a diagnosed illness or disability (for example, seizure disorder)

Yes______ No______

Other health problems (please be specific):

____

____

Is there any other condition that limits your child's daily activities? Yes______ No______

If so, please describe:

____

____

Has a doctor prescribed any medicine/vitamins for your child? Yes______ No______

If so, please list:

____

____

Is your child on a specific diet? Yes______ No______

If so, please describe:

____

____

Has your child ever had any serious accident or injury?

Are there any areas in which you have concerns about your child? Check all that apply.

_____ Eating

_____ Hearing

_____ Running or Moving

_____ Walking

_____Toileting

_____Using Hands

_____ Sleeping Habits

Please explain:

____

____

Daily Routine

Diaper Size__________ Potty-Trained: YES or NO

Does your child need prompting to go to the bathroom? YES or NO
List words used for toileting: ____

Special diapering/ toileting request____

Any other potty-training information:

____

____

***ALL CHILDREN MUST HAVE A COMPLETE CHANGE OF CLOTHES TO BE KEPT IN THEIR CUBBY AT ALL TIMES (top, bottom, underwear, socks, etc.)**

What time does your child go to bed at night? ____________________________________

What time does your child wake up in the morning? _______________________________

What time does your child typically nap during the day? ___________________________

Where does your child sleep? ____

How do you put your child to sleep?

____

____

Does your child drink: Formula Breast milk Milk

If your child is under 1, how much formula/breast milk does your child drink at a feeding? ___________oz

How many hours does your child go between eating ____________

Does your child eat jar food? If so, what type? ________________________________

Any restrictions? ____

Does your child eat table food? YES or NO

Any restrictions? ____

Per ISBE regulations, children under 1 must drink breast milk or formula. Children 1-2 years old must drink whole milk. Children 3 and older must drink 1% milk. If your child has special milk requests you must provide a doctor's note.

Social Characteristics

Name some positive personality traits about your child____

____

Is there anything your child is having trouble doing? ______________________________

____

How does your child interact with other children? ______________________________

____

How does your child express anger? ______________________________

____

What is the best way to help your child calm down? ______________________________

____

Describe your discipline methods (if any are used) ______________________________

____

Are there any areas you would like assistance or advice with your child? ______________

____

Are there any events that have happened in your child's life that have affected them mentally or physically? ______________________________

____

Any additional comments: ______________________________

____

Parent/Guardian signature: ______________________________

Thresholds Mother's Project Sick Policy

Your child's health is very important and is our primary concern while they are attending our daycare. This sick policy is in place to protect your child and others. If your child is sick, you will be notified and will need to pick up your child immediately. Please make sure that your current contact and emergency contacts are up to date. If we are unable to reach you, we will contact people on your emergency contact list.

Staff and teachers will assist in the administration of prescribed medications with a signed consent form from the parent.

Children may not enter the daycare if: the child has any virus, infection, or condition that is visible to caregiver and may be contagious or harmful to other children and staff. These illnesses include:

- Pink eye- a very contagious eye infection
- Ringworm- an itchy, red, circular rash, a fungal infection that develops on the top layer of skin
- Measles/mumps- irregular, bright red spots, with bluish-white specks in the center
- Chicken pox-itchy red pockmarks on the body
- Scabies- an itchy skin condition
- Runny nose with thick green mucus

If your child has any of these illnesses, you will need a doctor's note in order for them to return to daycare.

You will be called and required to pick up your child immediately if your child exhibits:

- Diarrhea- 3 loose bowel movements
- Vomiting- two or more times
- Staph- bumps on skin
- Head and body lice- small bugs that connect with skin
- Tetus- scalp disease
- Strep throat- sore throat, red and enlarged tonsils
- Mouth sores- with uncontrollable drooling
- Temperature- 100 degrees
- Rash with fever or behavior change
- Fever with behavior change or indication of symptoms of illness

EARLY LEARNING CENTER

SICK POLICY

ACKNOWLEDGEMENT OF RECEIT

I have received and read a copy of Threshold's Mother's Project Early Center's Sick Policy and by signing below I am in agreement and will comply with the guidelines of the policy.

____
Parent Signature

____
Staff Signature

DATTE______________________________

Early Learning Center Pick-up Policy

The Mother's Project Early Learning Center's hours are from 7:30AM-5:30PM. Later pick up from 4PM-5PM or early drop-off time from 7:30AM-8AM is available for mothers who show proof of work and or school schedule indicating additional time is needed. All other mothers are expected to drop off between 8AM-10:30AM and pick up between 2:30PM-4PM.

If parents do not abide by their set pick- up times, the following progressive interventions will be enforced:

Offense	*Consequence*	*Must Occur*
First Offense	Verbal Warning	Conversation with Daycare Director
Second Offense	Verbal Warning	Conversation with Daycare Director and written letter with parents signature to address incident
Third Offense	One-Day Suspension	Meeting with APD's, Program Director and Daycare Director
Fourth Offense	Two-Day Suspension	Leadership will discuss
Fifth Offense	Leadership will determine	Leadership will discuss

Signature____

Date____

Intoxicated/ Impaired child pick-up policy

To ensure that no child is allowed to leave the care of the Thresholds Learning center in the custody of a person who is in physical condition which may stop him or her from assuring the child's or children safety.

Any parent or other person who is authorized to pick up a child enrolled in Thresholds learning center comes to the center under the influence or in an emotional stage which may put child's safety at risk may not be allowed to pick-up a child.

In the event that a parent or other authorized person arrives at the center while under the influence or in an emotional stage, staff will use their best judgment in determining if he or she is in a condition which may stop them from assuring the child's well-being.

Should it be determined that the person is in a condition that stops them from assuring the child's well-being, staff will:

1. Make other arrangements for child pick-up, including, attempting to contact another person on the Authorized child pick-up list.
2. Center will use other services, if no authorized child pick-up person is available i.e. Lydia home or safe families
3. If the person is not a parent of the child, they will be removed from the list of individuals authorized to pick-up a child after the second incidence.

In the event that a parent is insisting to take the child under the influence or in an emotional stage, staff will inform local police and make a hotline call.

For any parent who arrives at the center under the influence or in emotional stage and is willing to work with the staff following will occur:

1. One written warning on the first incidence
2. Two day suspension will be given on the second incidence and hotline call
3. Loss of child care on the third incidence and hotline call

The Center Director, or if she or he is not present, the person in charge, is authorized to carry out the directives of this policy.

I have read the policy and by signing I indicated that I am in agreement.

Parent Signature: ____________________ Date: ____________________

Threshold's Mothers' Project

Educational Therapist Handbook

PERMISSION FOR VIDEO TAPING and FOR USE OF VIDEO TAPES

1.) I__________________________, hereby give permission for my child/children __________________________, ____________________________, and I to be video taped during our participation in the Mothers' Project operated by The Thresholds ("Thresholds").

2.) I give permission for Project Staff to use any video tapes produced to assist me and Project Staff in better understanding the behavior of myself and my child (ren). For the purposes of this permission, Project Staff includes all employees of Thresholds, Interns whether paid or unpaid, and any other persons working within the Project in a professional capacity.

3.) I also give permission for Thresholds to use any of the tapes produced in order to train Project Staff.

4.) I understand that any video tapes produced will become a record reflecting my participation and the participation of my child (children) named above in the Project. Consequently, it will be treated like other records of my participation in the Project and will be subject to confidentiality protections given medical and mental health records by local, state, or federal laws.

5.) I understand that the video taping is an essential part of our participation in the Project and that my refusal to consent to or give permission for the video taping or the use of the video tapes described above could jeopardize our participation in the Project. I also understand that I may revoke this permission at any time.

6.) The effect of this permission shall terminate one year after the termination of my participation in the Project.

__________________________________ Date________________
Printed name of person granting permission

__________________________________ ________________________ Date____
Signature of person granting permission Printed name of witness

____
Signature of witness

Thresholds Mothers' Project
Informed Consent for On-Going Assessments

As part of your child's educational programming through Thresholds Mothers' Project Early Learning Center, the teachers/parent educator will be completing developmental screenings as a means of monitoring their progress in school. These tools include the ASQ and ESI-R screenings. As the parent, you are invited and strongly encouraged to participate by completing the parent version of the Ages & Stages Questionnaire (ASQ-SE), which assess your child's social emotional development. The Learning Center staff will share the results of each screening with you. Screening information will be used in developing individualized lessons to address the unique developmental needs of your child. The results may also be used for research and data collection purposes. If your child's score requires follow-up, the screening information will be shared with early intervention agencies or Chicago Public Schools (for pre-k students only) in order to further screen/evaluate your child and ensure they are receiving all the services needed to reach their full potential.

___ I agree to participate in the ASQ and ESI-R Screenings

___ I decline to participate in these screening measures at this time.

I understand that my child will be involved in on-going assessments while at Mothers' Project Learning Center. I further understand that the results of the ASQ/ESI-R may be shared with necessary agencies for follow up assessments.

Parent Signature:______________________________ Date:______________

Witness Signature:_____________________________ Date: ______________

CFS 593
Rev 7/2007

State of Illinois
Department of Children and family Services

CONSENTS TO DAY CARE PROVIDERS

NAME OF CHILD____________________________________

THESE CONSENTS ARE FOR NON-DCFS WARDS ONLY AND MAY ONLY BE USED FOR DAY CARE SERVICES

Parents(s) or legal guardian placing the child may sign any or all of the following consents:

EMERGENCY MEDICAL CARE

This authorizes __________________________________
To secure EMERGENCY medical care for my child when I/we cannot be immediately reached at the time of emergency. I/we will be responsible for the emergency medical charges upon receipt of the statement
_________________________ is the preferred doctor/clinic/hospital.

Date________________

____
Signature of parent/guardian

____
Relationship to child

____
Signature of parent/guardian

____
Relationship to child

ADMINISTRATION PRESCRIPTION MEDICINE

I/we authorize______________________ to administer prescribed medicine to my/our child as specified in the prescription's directions for administration.

Date________________

____
Signature of parent/guardian

____
Relationship to child

____
Signature of parent/guardian

____
Relationship to child

This form is required for Child Care Centers, Pre-K, Head Start, Even Start, and Licensed Outside School Hours Programs.
This form is NOT required for At-Risk After-School, License-exempt Outside School Hours, or Emergency Shelters.

Parents/Centers: 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 or guardians to complete or review a CACFP Annual Enrollment Form when enrolling their child(ren) and every year thereafter. This information will help ensure all children receive appropriate meals during their care. The parent or center may complete Sections 1 through 4. The parent must review to ensure accuracy; then complete Section 5, sign and date Section 6. If parent does not complete Section 5, center staff should complete to the best of their ability (by observation) and initial the section. The center will review completed enrollment form.

1 FULL NAME OF ENROLLED CHILD (Include Birth Date/Age) | **2** DAYS OF WEEK IN ATTENDANCE | **3** TIMES CHILD NORMALLY ATTENDS DURING WEEK | **4** MEALS RECEIVED

First Child

Name
Birth Date
Age

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

TIME IN			TIME OUT			TIMES CHILD ATTENDS SCHOOL	
AM	PM	TIME	AM	PM	TIME	Leaves Center	Returns To Center

☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours

☐ Early Morning Snack ☐ Breakfast ☐ A.M. Snack ☐ Lunch ☐ P.M. Snack ☐ Supper ☐ Evening Snack

Second Child

☐ Same Days as Above | ☐ Same Times as Child Above | ☐ Same Meals as Above

Name
Birth Date
Age

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

TIME IN			TIME OUT			TIMES CHILD ATTENDS SCHOOL	
AM	PM	TIME	AM	PM	TIME	Leaves Center	Returns To Center

☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours

☐ Early Morning Snack ☐ Breakfast ☐ A.M. Snack ☐ Lunch ☐ P.M. Snack ☐ Supper ☐ Evening Snack

Third Child

☐ Same Days as Above | ☐ Same Times as Child Above | ☐ Same Meals as Above

Name
Birth Date
Age

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

TIME IN			TIME OUT			TIMES CHILD ATTENDS SCHOOL	
AM	PM	TIME	AM	PM	TIME	Leaves Center	Returns To Center

☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours

☐ Early Morning Snack ☐ Breakfast ☐ A.M. Snack ☐ Lunch ☐ P.M. Snack ☐ Supper ☐ Evening Snack

Please answer both questions. This information is voluntary.

5 ETHNIC/RACIAL CATEGORIES—

A. Ethnic data of child(ren) — Mark only one. ☐ Hispanic or Latino ☐ Not Hispanic or Latino

B. Racial data of child(ren) — Mark one or more that apply. ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ American Indian or Alaska Native

6 SIGNATURE
I certify the information above is correct.

Signature of Parent or Guardian _______ *Date* _______ *Telephone Number of Parent or Guardian* _______

CHILD CARE REPRESENTATIVE USE ONLY

Effective Date of this enrollment form: ____________________

The effective date may be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month in which 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

1. All Household Members

NAMES OF ALL HOUSEHOLD MEMBERS First, Middle Initial, Last	Ages of Children at Center	2. FOSTER CHILD Foster children are a legal responsibility of DCFS or court. If all are foster children, skip to #6.	3. SNAP OR TANF CASE NUMBER Skip to Part 6 if you list a SNAP or TANF case number. At least one SNAP/TANF must be provided below.
		☐	___ - ___ - ___ - ___
		☐	___ - ___ - ___ - ___
		☐	___ - ___ - ___ - ___
		☐	___ - ___ - ___ - ___
		☐	___ - ___ - ___ - ___
		☐	___ - ___ - ___ - ___

4. Homeless, Migrant, or Runaway

☐ Homeless ☐ Migrant ☐ Runaway

Signature of School Homeless Liaison or Migrant Coordinator _______________ Date _______

5. Total Household Gross Income (before deductions) You must tell us how much and how often.

GROSS INCOME AND HOW OFTEN IT WAS RECEIVED (Example: $100/month; $100 /twice a month; $100/every other week; $100/week)

NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)	Earnings From Work (Before Deductions)		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		Worker's Comp., Unemployment, SSI, etc. (All other income)	
	Amount	How often?	Amount	How often?	Amount	How often?	Amount	How often?
i.	$		$		$		$	
ii.	$		$		$		$	
iii.	$		$		$		$	
iv.	$		$		$		$	
v.	$		$		$		$	

6. Signature and Social Security Number (Adult must sign)

An adult household member must sign the application. If Part 5 is completed or if zero income is listed, the adult signing the form must also list the last four digits his or her social security number or mark the *I do not have a social security number* box.

X X X - X X - ___ ___ ___ ___
Social Security Number

☐ I do not have a social security number.

I certify all information on this application is true and all income is reported. I understand the center will get federal funds based on the information I give. I understand the institution, Illinois State Board of Education, or Office of Inspector General, may verify this information on the application. Deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

_______________ Date

_______________ *Printed Name of Adult Household Member*

_______________ *Signature of Adult Household Member*

7. Contact Information (Optional)

_______________ *Work Telephone Number (Include Area Code)*

_______________ *Home Telephone Number (Include Area Code)*

_______________ *Home Address (Number, Street, City, State, Zip Code)*

8. Optional – Sharing Information With All Kids Insurance Program

May we share your information on this application with the *All Kids Insurance Program*, the complete health insurance program for every child in Illinois? If *yes*, do not sign below.

☐ No, I do not want my information from this application shared with the *All Kids Insurance Program.*

Date: _______________ Sign here: _______________

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 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 or other FDPIR identifier for your child 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 Child and Adult Care Food Program. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

CHILD CARE REPRESENTATIVE USE ONLY—ELIGIBILITY DETERMINATION - COMPLETE SECTIONS A, B and C BELOW

Follow the *Instructions for Institutions to Process Household Eligibility Applications* available at *www.isbe.net/nutrition*.

SECTION A Annual Income Conversion Weekly X 52 Every 2 Weeks X 26 Twice a Month X 24 Once a Month X 12

Convert income only if different frequencies of pay are reported.

TOTAL INCOME $ _______________ Per: ☐ Week ☐ Every 2 Weeks ☐ Twice a Month ☐ Month ☐ Year NUMBER IN HOUSEHOLD: _____

☐ Free based on:
- ☐ foster child
- ☐ SNAP or TANF
- ☐ homeless
- ☐ migrant
- ☐ runaway
- ☐ household's income

☐ Reduced based on:
- ☐ household's income

☐ Denied—Reason:
- ☐ Income too high
- ☐ Incomplete application
- ☐ Non-qualifying SNAP/TANF

SECTION B Signature of Determining Official _______________ Date _______

SECTION C Effective Date of this application: _______________

The effective date may be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month in which the child's eligibility is certified.