



NYC Early Learning
Company, Inc.



Beanstalk Academy **ENROLLMENT APPLICATION**





GENERAL

- Application Forms** (pages 1-8)
- Medical form & Immunizations records**
- Proof of Age** (birth certificate, passport, or other official document of age)
- CACFP (Enrollment form, Eligibility Form and Infant feeding form** (when applicable))
- IEP / IFSP** (when applicable)

HS/EHS

- Proof of Income** (4 paystubs, public assistance letter, W2 or tax returns)
- Foster care or homeless documentation** (when applicable)

DOE/UPK

- 2 Proofs of Address** (you may provide an electric or water bill, your lease agreement or mortgage statement, a federal or state letter addressed to parent) and your NYS ID
- Offer Letter** (you can print this from your MySchools account)
- Proof of Income** (only for extended day & year program) (4 paystubs, public assistance letter, W2 or tax returns)
- Foster care or homeless documentation** (when applicable)

IF YOUR CHILD HAS

- Asthma** - Asthma Action Plan
- Allergies** - Allergy Plan
- Medication for allergies or asthma please have your doctor complete the **Medication Administration Form.**



Please do not leave anything blank.
If something does not apply to you, please write "N/A"

Today's Date: _____

Child's Information _____ DOB: _____
(Last name, First name, Middle Initial)

Street Address: _____ Apt #: _____

City: _____ State: _____ ZIP: _____ Language: _____

Gender: M F Hispanic or Latino: Yes No Secondary Language: _____

HRA/ACS Case Number: _____ Language Proficiency: Little Moderate None Proficient

Race: American Indian or Alaska Native Asian Black or African American Bi-Racial/Multi-Racial

Native Hawaiian or other Pacific Islander White Other (Explain) _____

Birth Certificate: Submitted Don't have Lost

Current Living Situation: Foster Homeless

Parent/Guardian #1 _____ DOB: _____
(Last name, First name, Middle Initial)

Relationship to child: Parent Grandparent Relative (other than grandparent) Foster Other: _____

Family: Single Parent Household 2 Parent Household

Email: _____ Phone #: _____ f / _____ @ / _____

Parent Education (highest grade):

- An advanced degree or baccalaureate degree
- An associate degree, vocational school, or some college
- A high school graduate or GED
- Less than high school graduate

Employment:

- Employed
- Unemployed
- Training
- School

Military:

- Veteran
- Active duty

Number of family members living in the household being supported through the family income: _____

Public Assistance status: TANF SSI WIC SNAP

Parent/Guardian #2 _____ DOB: _____
(Last name, First name, Middle Initial)

Relationship to child: Parent Grandparent Relative (other than grandparent) Foster Other: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ ZIP: _____

Email: _____ Phone #: _____ f / _____ @ / _____

Parent Education (highest grade):

- An advanced degree or baccalaureate degree
- An associate degree, vocational school, or some college
- A high school graduate or GED
- Less than high school graduate

Employment:

- Employed
- Unemployed
- Training
- School

Military:

- Veteran
- Active duty



Child: _____
(Last name) (First name) (DOB)

Child's Health Information

Private Insurance No Insurance Medicaid CHIP Policy #: _____

Primary Care Physician: _____ Phone #: _____

Address: _____

Dentist: _____ Phone #: _____

Address: _____

Nutrition Information: Full Diet / No Restrictions Nutritional Concern / Special Diet: _____

Does your child have any allergies? Yes No

Does your child have any chronic conditions? Yes No

If yes:

ACD ADHD Asthma Seizures Allergies Hearing Vision Diabetes

BLL >5 Other: _____

Related Services

Do you have any concerns regarding your child's development? Yes No

If yes, please explain: _____

Has your child been evaluated due to your concern or ever received services? Yes No

Does your child have an IEP or IFSP? Yes No

If yes: What services are they receiving? OT PT SPEECH ABA COUNSELING

SEIT Other: _____

_____ I certify that the information provided is correct to the best of my knowledge and is subject to verification.

Parent / Guardian Signature: _____ Date: _____



Emergency Contact and Authorized Escort List

To maintain the safety of your children, parents/guardians must complete, sign, and return this form to Beanstalk Academy upon enrollment. This form shall be updated annually or when there is any change in authorized escort information.

Emergency Contacts: Only individuals listed (and checked off) below will be considered as designated emergency contacts. Parents and guardians do not have to be listed below. An emergency contact is someone who Beanstalk Child Care Academy has permission to contact in the event that a parent/guardian cannot be reached during an emergency, for the purpose of communicating critical information.

Authorized Escort(s): Only individuals listed (and checked off) below will be considered as an authorized escort(s) and will be allowed to pick-up your child. Parents and guardians do not have to be listed below. Government issued ID will be required at time of pick-up. All authorized escorts must be above 16 years of age.

The New York City Health Code requires Child Care Centers to obtain and maintain for every child a list of all persons authorized by parents/guardians to escort the child from Child Care. No child may leave the Center with any individual whose name is not on file at the Center as an authorized escort.

Name: _____ Relationship to Child: _____ Phone #: _____ Home Address: _____ <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Authorized Escort	Name: _____ Relationship to Child: _____ Phone #: _____ Home Address: _____ <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Authorized Escort
Name: _____ Relationship to Child: _____ Phone #: _____ Home Address: _____ <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Authorized Escort	Name: _____ Relationship to Child: _____ Phone #: _____ Home Address: _____ <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Authorized Escort
Name: _____ Relationship to Child: _____ Phone #: _____ Home Address: _____ <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Authorized Escort	Name: _____ Relationship to Child: _____ Phone #: _____ Home Address: _____ <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Authorized Escort

I, _____ (parent/guardian last name, first name, middle initial) authorize Beanstalk Academy to contact in case of emergency or to release my child _____ (child last name, first name, middle initial) to the individuals I have identified above.

Parent / Guardian Signature: _____

Date: _____



General Consents

Child: _____
(Last name) (First name) (DOB)

Parent/Guardian: _____
(Last name) (First name)

Neighborhood Walking Trip Consent *(please initial)*

_____ I give permission for my child to participate in neighborhood walking trips including walks to local parks and playgrounds. Field trips require a separate consent form and will be sent home prior to any field trip.

Photo Consent *(please initial)*

_____ I hereby give Beanstalk Academy and its subsidiaries (hereafter referred to as Beanstalk Academy and those acting with Beanstalk Academy) permission and authority to use, publish and/or republish photographic pictures of myself and/or my minor child.

The photographic pictures may be altered in character or form on reproductions in color and/or black and white through any media used by Beanstalk Academy for any Beanstalk Academy purpose including, without limitation, use in any printed materials, on Beanstalk Academy's website on the internet and related websites, and in social media.

I release and discharge Beanstalk Academy and its representatives, employees, or any person(s) and/or corporation(s) for whom Beanstalk Academy may be acting, including any firm publishing and/or distributing the finished product, in whole or in part, from any liability resulting from the distortion, blurring, alteration, or optical illusion, either unintentionally or otherwise, that occurs or is produced in the taking, processing, or reproduction of the finished product, its publication and/or distribution.

By signing below, I also acknowledge that:

I understand and agree to all consents and screenings listed on this form. The authorization remains effective throughout my child's enrollment, but I may also choose to revoke it at any time by notifying Beanstalk Academy in writing. I am over 18 years of age and competent to contract in my own name. I have the authority to execute this document on behalf of my minor child.

Parent / Guardian Signature: _____ **Date:** _____



Medical Consents

Child: _____
(Last name) (First name) (DOB)

Parent/Guardian: _____
(Last name) (First name)

OTC Medications *(please initial)*

_____ I give permission for the administration of the following non-ingestible over the counter medications, including sunscreen, diaper creams, and insect repellent, as needed. I understand that such OTC medication will be brought to school in its original container and will be clearly labeled with my child's name.

Consent for Epinephrine Administration (EpiPen) *(please initial)*

_____ In the event that my child experiences a severe allergic reaction while under the supervision of Beanstalk Academy, I hereby grant the school permission to administer an initial dose of Epinephrine and then immediately call 911. I understand that, should emergency services direct the school to do so, a 2nd dose of Epinephrine may be administered to ensure the child's imminent safety.

Emergency Treatment Authorization

I _____ hereby state that I am the legal guardian(s) of _____

DOB _____, who resides with me at _____. I authorize that for emergency purposes, a school designated employee may provide consent for my child to receive medical attention (e.g. necessary examination, medical diagnosis, surgery, treatment, and/ or EMS/hospital care). In the event that my child needs to be transported, a Beanstalk Academy staff member will accompany my child at all times. I understand that every effort will be made to contact the Emergency Contact persons provided in the Emergency Release Contact Form.

By signing below, I also acknowledge that:

I understand and agree to all consents and screenings listed on this form. The authorization remains effective throughout my child's enrollment, but I may also choose to revoke it at any time by notifying Beanstalk Academy in writing. I am over 18 years of age and competent to contract in my own name. I have the authority to execute this document on behalf of my minor child.

Parent / Guardian Signature: _____ **Date:** _____



Child Screenings

Child: _____
(Last name) (First name) (DOB)

Parent/Guardian: _____
(Last name) (First name)

To ensure the health and development of your children, Beanstalk Academy will be conducting various screenings, which will be performed either by in-house staff or fully certified external resources hired or contracted by Beanstalk Academy. All screenings will be done on the premises, with results and feedback communicated to the family in a timely manner. The following is a list of screenings that Beanstalk Academy may conduct:

Please initial:

_____ **Hearing**

An age-appropriate hearing screening will be performed within 45 days of enrollment and annually.

_____ **Vision**

An age-appropriate vision screening will be performed within 45 days of enrollment and annually thereafter.

_____ **Blood Pressure**

Children aged 3 and older will have their blood pressure checked annually.

_____ **HGB**

Hemoglobin blood levels will be checked annually.

_____ **Dental Screening**

Dental Screenings will be provided to children within 90 days of enrollment and annually thereafter.

_____ **Social Emotional**

Parents and center-based staff will collaborate to complete a behavioral questionnaire for each child within 45 days of enrollment and annually thereafter.

_____ **Development and ED**

Education staff will conduct a developmental screening within 45 days of enrollment and annually thereafter.

_____ **Growth Assessment**

Child's height and weight will be measured and recorded every six months.

_____ **Nutrition Assessment**

With information provided by families, a nutritionist will conduct a dietary/growth assessment within 90 days of enrollment and annually thereafter.

_____ **Mental Health**

Mental Health professionals will conduct classroom observations and provide referrals or classroom support as applicable.

_____ I give permission for Beanstalk Academy to conduct all health and developmental screenings as listed above or as deemed necessary. Screenings may be done by either Beanstalk Academy staff/consultants or by certified organizations who partner with Beanstalk Academy for the health and well-being of my child.

By signing below, I also acknowledge that:

I understand and agree to all consents and screenings listed on this form. The authorization remains effective throughout my child's enrollment, but I may also choose to revoke it at any time by notifying Beanstalk Academy in writing. I am over 18 years of age and competent to contract in my own name. I have the authority to execute this document on behalf of my minor child.

Parent / Guardian Signature: _____

Date: _____



Consent to Obtain and Release Child Information

Child: _____
(Last name) (First name) (DOB)

Parent/Guardian Name(s): _____

Please initial:

_____ I authorize Beanstalk Academy to share Information with early intervention / Local educational agencies from my child's records for purposes pertaining to his/her overall development. I understand these conversations will be confidential and respectful with the goal of helping my child grow and learn which will increase their overall success in the program.

_____ I hereby authorize any early intervention / local educational agencies / Medical agencies to release and obtain information and/or copies of files pertaining to my child (including medical forms, IFSP or IEP, evaluation, session notes) to Beanstalk Academy. I also understand this information may be shared with other partner agencies working with my child for the purposes of providing services, screenings and/or evaluations.

- **IEP**

Individualized Education Plan; document from NYSED that outlines mandated special education and/or related services.

- **IFSP**

Individualized Family Services Plan; document from NYSDOH's Early Intervention Program that outlines mandated special education and or related services.

- **Nutrition**

Nutrition Screenings assess a child's dietary and growth patterns as well as best recommendations.

- **Anecdotal Child Development**

Teacher notes that reflect on a child's progress and behavior within the classroom setting.

- **Mental Health**

Mental Health Screenings, General Observations, Referrals, or Recommended Behavior Intervention Plans

- **Medical Records**

Annual physicals, well-check documentation, immunization records, etc.

By signing below, I also acknowledge that:

I understand and agree to all consents and screenings listed on this form. The authorization remains effective throughout my child's enrollment, but I may also choose to revoke it at any time by notifying Beanstalk Academy in writing. I am over 18 years of age and competent to contract in my own name. I have the authority to execute this document on behalf of my minor child.

Parent / Guardian Signature: _____ **Date:** _____

Beanstalk Academy
CACFP ENROLLMENT FORM



NYC Early Learning
Company, Inc.



My Child, _____ DOB: ____/____/____ is enrolled at
NYC Early Learning Company (Beanstalk Academy). His/her start date is ____/____/____.

My child will attend: Monday Tuesday Wednesday Thursday Friday

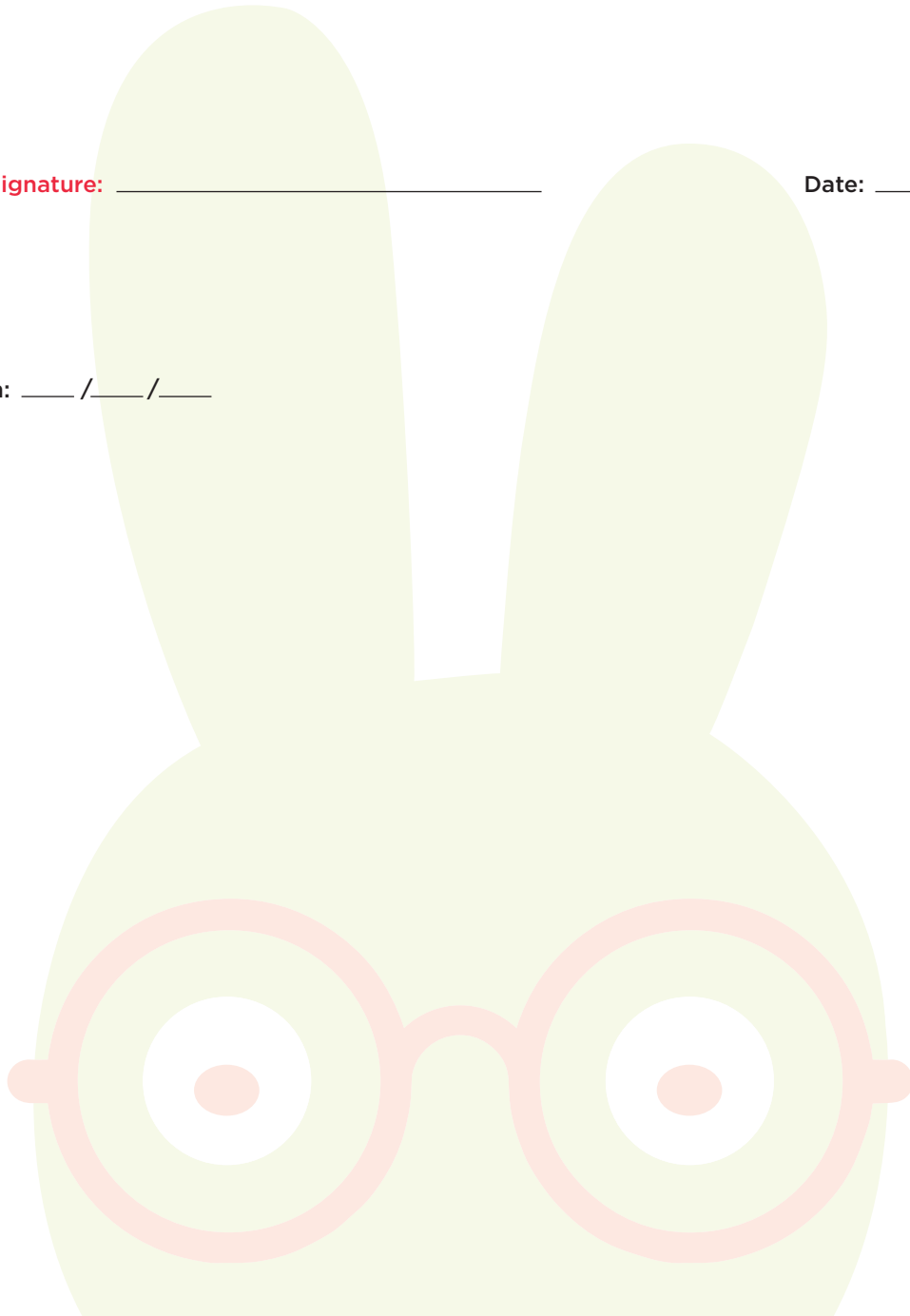
Hours of Care: 7:30 am - 6:00 pm

Receiving Meals: Breakfast Lunch PM Snack

Parent / Guardian Signature: _____

Date: _____

Child Withdrawn on: ____/____/____



See INSTRUCTIONS on reverse.

CHILD CARE CENTER NAME NYC EARLY LEARNING COMPANY INC - BEANSTALK CHILDCARE ACADEMY

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 # <u>6806</u>	
Total Number of Household Members _____ <small>(INCLUDING FOSTER CHILDREN, IF APPLICABLE)</small>	
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

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 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.



INFANT FEEDING STATEMENT

Baby's Name _____ Date of Birth _____

Dear Parent/Guardian:

This center participates in the Child and Adult Care Food Program and we will give your baby Enfamil Gentlease/Infant and solid food. If you want to bring breast milk or your own NAME OF FORMULA formula or food, you can do that instead. Also, we encourage moms to come to the center to nurse their babies.

Please indicate your choice below.

BREAST MILK/FORMULA (CHECK ONE)	FOOD (CHECK ONE)
_____ The center can give my baby the formula they buy.	_____ The center can give my baby solid foods when I tell them the baby is ready.
_____ I will bring breast milk or formula for my baby.	_____ I will bring solid foods for my baby.

Parent's Signature _____ Date _____

This institution is an equal opportunity provider.

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

