EARLY LEARNING APPLICATION PACKET

Thank you for your interest in our Early Learning Program. Attached is our application with the necessary forms needed to start your child's enrollment process. Please take a few minutes to fill out the information below so we can assist you with the enrollment process.

Today's Date:	
Name of child Applicant:	
Child's date of Birth	
Parent/Guardian Name	
Address	
Phone #	
Email Address	

OFFICE USE ONLY
Caseworker follow-up:

1st contact date: _____
(within 2wks from app pick-up) (REMIND PARENT TO COMPLETE DENTAL/MAKE APPOINTMENT)

_____

_____

☐No longer interested ☐ application incomplete /waiting on documentation ☐Appt made
☐Application submitted ☐Continue follow-up

2nd contact date: _____
(if applicable, within 2wks of 1st contact)

_____

_____

☐No longer interested ☐ application incomplete /waiting on documentation ☐Appt made
☐Application submitted ☐ Continue follow-up

ALLIANCE
FOR COMMUNITY EMPOWERMENT

Early Learning Application

Dear Parent or Guardian:

Thank you so much your interest in the programs offered at ALLIANCE FOR COMMUNITY EMPOWERMENT. I have enclosed the required application packet for you to complete. I have also included a flyer that provides you with information about our Early Learning programs and their locations. Please bring the following items when you return the application:

- Birth verification (Birth certificate, Passport, Hospital Certificate, etc.)
- Social Security Numbers for the family
- Child's Medical Insurance Card
- Guardianship documents (If applicable)
- Parent or Guardian's proof of income (if no income, zero income affidavit will be filled out)
- Most recent monthly pay stubs
- State Budget form (for one month of income)
- Child's Physical, Immunization and Dental form (or proof of dental appointment)
- Two emergency names and telephone number
- If the child is receiving services a copy of the IFSP/IEP

You can return the completed packet to our Early Learning Department at 1070 Park Ave, or to the site of your choice. For more information please call us at (203) 366-8241 Ext 3221

Thank you!

Estimado Padre / encargado:

Muchas gracias por su interés en los programas ofrecidos por ALLIANCE FOR COMMUNITY EMPOWERMENT. Adjunto encontraran los formularios requeridos para que usted pueda completar su aplicación. Se incluye además folletos que contienen información acerca de los programas de cuidado de niños y las localizaciones de los mismos. Los siguientes documentos son requeridos para poder procesar la aplicación de su niño(a):

- Verificación de nacimiento (Certificado de nacimiento, pasaporte, certificado de hospital, etc.)
- Los número de Seguro Social de la familia
- Tarjeta del seguro médico del niño
- Prueba de Ingreso Económico (Padre o Encargado)
- Deben ser talonarios de pagos recientes o carta oficial del estado
- Prueba de custodia
- Examen físico completo (debe incluir las vacunas)
- Examen dental (o prueba de cita con dentista)
- Dos nombres de emergencia y número de teléfono
- Si el niño recive algún orto servicio, traer una copia del el plan de servicio Familiar Indivualizado (IFSP)

Usted puede devolver estos formularios a 1070 Park Ave o algún de los otros centros. Para más información llame al teléfono (203) 366-8241 Ext 3221

Mucha Gracias!

August 2021

ALLIANCE FOR COMMUNITY EMPOWERMENT

Early Learning Application

EARLY LEARNING APPLICATION **Child Plus ID#_____**

Applicant/Child Information

Child's/Applicant's Name:

First: Middle: Last:

Address:
House/ Apartment # & Street Name:

City: State: Zip Code:

Date of Birth: Telephone: Email Address:
Phone #1: Phone #2:

Gender:

Male:_____ Female:_____

Language(s):

Primary: Secondary:

English Speaking Ability:

Very Well:___ Well:___ Not Well:___ Not at all:___

Mode of Transportation: Walk:____ Own car:____ Friend's/Family member car/ride:____ Public:____

Services Needed:
Full Day/ Full Year:_____ Part Day/ Part Year:_____ Home Base:_____ Transitioning from EHS/DC:_____

Family/Household Information

Mother of child: Lives with child: yes____ no____

Father of child: Lives with child: yes____ no____

Guardian's name: Relationship to child:

Names of other children in the household	DOB	Relationship to child/applicant	Other adult members in the household (over 18yrs of age)	DOB	Relationship to child/applicant

I certify that the information provided in this application is accurate and truthful to the best of my knowledge

Parent/Guardian Signature:

I would like refer an eligible family to your program: Name: Phone#:

Confidentiality Statement: All information shared with Early Learning Staff will be kept strictly confidential unless its release is authorized in writing. These forms will be maintained in locked files.

For office use only

Date received: Staff Signature:

August 2021

ALLIANCE FOR COMMUNITY EMPOWERMENT

Early Learning Application

APLICACIÓN DE EARLY LEARNING

Informacion del solicitante / nino

Nombre del solicitante/ niño :

Nombre: Medio: Apellido:

Dirección:
Casa / apartamento # & nombre de la calle:

Ciudad:	Estado:	Código postal:
Fecha de nacimiento:	Teléfono: Correo electrónico: Teléfono # 1: Teléfono # 2:	
Género: Macho:_____ Hembra: _____	Idioma (s): Primaria: Secundaria:	Capacidad de hablar Ingles: Muy bien:____ Bien:____ Regular:____ No sabes:____

Modo de transporte: caminar:____ coche propio:____ amigo / familia miembros coche/paseo:____ público:___

Servicios necesarios:
Todo día / todo año:____ Día parte / parte año:____ Programa de Home Base;_____ Pasando de EHS/DC:_____

Informacion de la familia/hogar

Madre de niño:	Vive con niños: sí no ____
Padre de niño:	Vive con niños: sí no ____
Nombre del encargado:	Relación al niño:

Nombres de otros niños en el hogar	Edad	Relación con el niño (solicitante)	Otros miembros adultos en el hogar (más de 18 años de edad)	Edad	Relación con el niño (solicitante)

Certifico que la información proveída en esta aplicación es correcta y verdadera de acuerdo a mi mejor conocimiento

Firma del padre/encargado:

Quiero referir a otra familia a su programa: Nombre: Teléfono #:

Declaración de confidencialidad: Toda información compartida será mantenida estrictamente confidencial a menos que usted lo autorices por escrito. Estos formularios serán manteniendo bajo llave.

Para uso de oficina solamente:

Date received: Staff Signature:

August 2021

State of Connecticut Department of Education

Early Childhood Health Assessment Record

(For children ages birth – 5)

To Parent or Guardian: In order to provide the best experience, early childhood providers must understand your child's health needs. This form requests information from you (Part I) which will be helpful to the health care provider when he or she completes the health evaluation (Part II). State law requires complete primary immunizations and a health assessment by a physician, an advanced practice registered nurse, a physician assistant, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to entering an early childhood program in Connecticut.

Please print

Child's Name (Last, First, Middle)	Birth Date (mm/dd/yyyy)	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone / Cell Phone	
Early Childhood Program (Name and Phone Number)	Race/Ethnicity ❑ American Indian/Alaskan Native ❑ Hispanic/Latino ❑ Black, not of Hispanic origin ❑ Asian/Pacific Islander ❑ White, not of Hispanic origin ❑ Other	
Primary Health Care Provider: Name of Dentist:		
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance? Y N
Does your child have dental insurance? Y N
Does your child have HUSKY insurance? Y N

If your child does not have health insurance, call **1-877-CT-HUSKY**

* If applicable

Part I — To be completed by parent/guardian.
Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Frequent ear infections	Y	N	Asthma treatment	Y	N
Allergies to food, bee stings, insects	Y	N	Any speech issues	Y	N	Seizure	Y	N
Allergies to medication	Y	N	Any problems with teeth	Y	N	Diabetes	Y	N
Any other allergies	Y	N	Has your child had a dental examination in the last 6 months	Y	N	Any heart problems	Y	N
Any daily/ongoing medications	Y	N				Emergency room visits	Y	N
Any problems with vision	Y	N	Very high or low activity level	Y	N	Any major illness or injury	Y	N
Uses contacts or glasses	Y	N	Weight concerns	Y	N	Any operations/surgeries	Y	N
Any hearing concerns	Y	N	Problems breathing or coughing	Y	N	Lead concerns/poisoning	Y	N
Developmental — Any concern about your child's:						Sleeping concerns	Y	N
1. Physical development	Y	N	5. Ability to communicate needs	Y	N	High blood pressure	Y	N
2. Movement from one place to another	Y	N	6. Interaction with others	Y	N	Eating concerns	Y	N
			7. Behavior	Y	N	Toileting concerns	Y	N
3. Social development	Y	N	8. Ability to understand	Y	N	Birth to 3 services	Y	N
4. Emotional development	Y	N	9. Ability to use their hands	Y	N	Preschool Special Education	Y	N

Explain all "yes" answers or provide any additional information:

Have you talked with your child's primary health care provider about any of the above concerns? Y N

Please list any **medications** your child will need to take during program hours:

*All medications taken in child care programs require a separate **Medication Authorization Form** signed by an authorized prescriber and parent/guardian.*

I give my consent for my child's health care provider and early childhood provider or health/nurse consultant/coordinator to discuss the information on this form for confidential use in meeting my child's health and educational needs in the early childhood program.

Signature of Parent/Guardian Date

Part II — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation, physical examination and immunization record.

Child's Name _____ Birth Date _____ (mm/dd/yyyy) Date of Exam _____ (mm/dd/yyyy)

❑ I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider.

***HT** ____ in/cm ____% ***Weight** ____ lbs. ____ oz / ____% **BMI** ____ / ____% ***HC** ____ in/cm ____% (Birth – 24 months) ***Blood Pressure** ____ / ____ (Annually at 3 – 5 years)

Screenings

***Vision Screening**

❑ EPSDT Subjective Screen Completed (Birth to 3 yrs)

❑ EPSDT Annually at 3 yrs (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑ Unable to assess

❑ Referral made to: _____

***Hearing Screening**

❑ EPSDT Subjective Screen Completed (Birth to 4 yrs)

❑ EPSDT Annually at 4 yrs (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
	❑ Pass	❑ Pass
	❑ Fail	❑ Fail

❑ Unable to assess

❑ Referral made to: _____

***Anemia:** at 9 to 12 months and 2 years

***Hgb/Hct:** *Date

***Lead:** at 1 and 2 years; if no result screen between 25 – 72 months

Lead poisoning (≥ 10ug/dL)

❑ No ❑ Yes

***TB:** High-risk group? ❑ No ❑ Yes

Test done: ❑ No ❑ Yes Date: _____

Results: _____

Treatment: _____

***Dental Concerns** ❑ No ❑ Yes

❑ Referral made to: _____

Has this child received dental care in the last 6 months? ❑ No ❑ Yes

*Result/Level: *Date

Other:

***Developmental Assessment:** (Birth – 5 years) ❑ No ❑ Yes **Type:**

Results:

*IMMUNIZATIONS ❑ Up to Date or ❑ Catch-up Schedule: MUST HAVE IMMUNIZATION RECORD ATTACHED

***Chronic Disease Assessment:**

Asthma ❑ No ❑ Yes: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent ❑ Exercise induced
*If yes, please provide a copy of an **Asthma Action Plan***
❑ Rescue medication required in child care setting: ❑ No ❑ Yes

Allergies ❑ No ❑ Yes: _____
Epi Pen required: ❑ No ❑ Yes
History/risk of Anaphylaxis: ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Medication ❑ Unknown source
*If yes, please provide a copy of the **Emergency Allergy Plan***

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II **Other Chronic Disease:** _____

Seizures ❑ No ❑ Yes: Type: _____ _____

❑ This child has the following problems which may adversely affect his or her educational experience:
❑ Vision ❑ Auditory ❑ Speech/Language ❑ Physical ❑ Emotional/Social ❑ Behavior

❑ This child has a developmental delay/disability that may require intervention at the program.

❑ This child has a special health care need which may require intervention at the program, e.g., special diet, long-term/ongoing/daily/emergency medication, history of contagious disease. *Specify:*_____

_____

❑ No ❑ Yes This child has a medical or emotional illness/disorder that now poses a risk to other children or affects his/her ability to participate safely in the program.

❑ No ❑ Yes Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.

❑ No ❑ Yes This child may fully participate in the program.

❑ No ❑ Yes This child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.)

_____

❑ No ❑ Yes Is this the child's medical home? ❑ I would like to discuss information in this report with the early childhood provider and/or nurse/health consultant/coordinator.

_____

Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number

Child's Name: _____ **Birth Date:** _____ REV. 8/2011

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) _____

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP/DT						
IPV/OPV						
MMR						
Measles						
Mumps						
Rubella						
Hib						
Hepatitis A						
Hepatitis B						
Varicella						
PCV* vaccine					*Pneumococcal conjugate vaccine	
Rotavirus						
MCV**					**Meningococcal conjugate vaccine	
Flu						
Other						

Disease history for varicella (chickenpox) _____
(Date) (Confirmed by)

Exemption: **Religious** _____ **Medical: Permanent** _____ **†Temporary** _____ **Date** _____
†Recertify Date _____ †Recertify Date _____ †Recertify Date _____

Immunization Requirements for Connecticut Day Care, Family Day Care and Group Day Care Homes

Vaccines	Under 2 months of age	By 3 months of age	By 5 months of age	By 7 months of age	By 16 months of age	16–18 months of age	By 19 months of age	2-3 years of age (24-35 mos.)	3-5 years of age (36-59 mos.)
DTP/DTaP/ DT	None	1 dose	2 doses	3 doses	3 doses	3 doses	4 doses	4 doses	4 doses
Polio	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
MMR	None	None	None	None	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]
Hep B	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
HIB	None	1 dose	2 doses	2 or 3 doses depending on vaccine given[3]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]
Varicella	None	None	None	None	None	None	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]
Pneumococcal Conjugate Vaccine (PCV)	None	1 dose	2 doses	3 doses	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday
Hepatitis A	None	None	None	None	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	2 doses given 6 months apart[5]	2 doses given 6 months apart[5]
Influenza	None	None	None	1 or 2 doses	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]

1. Laboratory confirmed immunity also acceptable
2. Physician diagnosis of disease
3. A complete primary series is 2 doses of PRP-OMP (PedvaxHIB) or 3 doses of HbOC (ActHib or Pentacel)
4. As a final booster dose if the child completed the primary series before age 12 months. Children who receive the first dose of Hib on or after 12 months of age and before 15 months of age are required to have 2 doses. Children who received the first dose of Hib vaccine on or after 15 months of age are required to have only one dose
5. Hepatitis A is required for all children born after January 1, 2009
6. Two doses in the same flu season are required for children who have not previously received an influenza vaccination, with a single dose required during subsequent seasons

_____

Initial/Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number

ALLIANCE
FOR COMMUNITY EMPOWERMENT

Early Learning Application

Dear Parent,
Take the Dental Exam Form to the Dentist. It is very important that your child has a dental exam before he/she is enrolled in the Child Care Program at ABCD Inc.

Your child's doctor cannot complete this form.
If you do not have a dentist let us know. We will help you to locate a dentist.

Estimados padres,
Tomar esta forma de Examen Dental al Dentista. Es muy importante que su hijo tenga un examen dental antes de que él o ella está inscrito en el programa en ABCD Inc.

El pediatra no puede completar este formulario.
Si usted no tiene un dentista nos dejó saber. Te ayudaremos a localizar a un dentista.

ALLIANCE
FOR COMMUNITY EMPOWERMENT

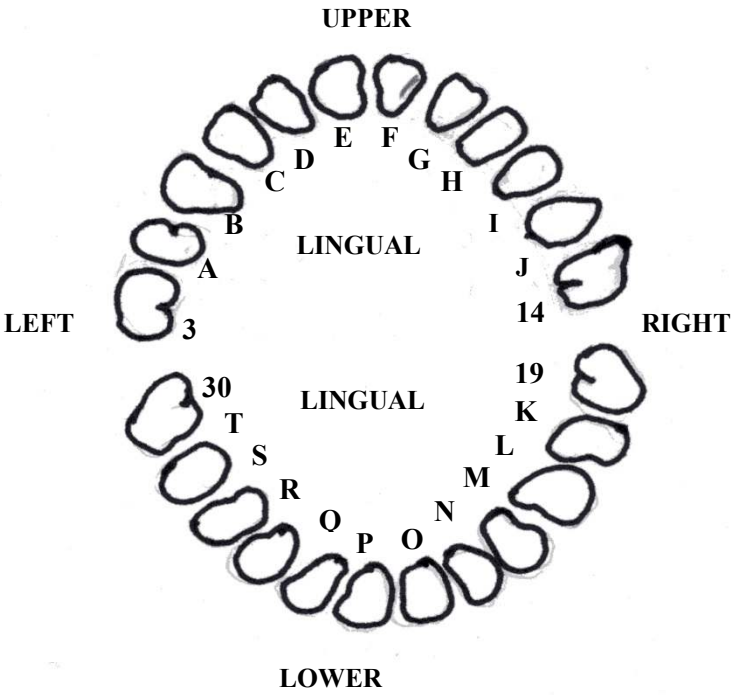
Early Learning Application

Dental Form

Name of the Child : _____

Date of Birth: _____

Date of Dentist Visit: _____



REASON FOR DENTAL VISIT

1 ☐ ORAL EXAMINATION

2 ☐ PREVENTIVE CARE

- ☐ Cleaning
- ☐ Flouride Application
- ☐ Sealant Application

3 ☐ TREATMENT

- ☐ Extraction
- ☐ Restoration
- ☐ Pulp Therapy

If Follow –up or work is needed please provide appointment date:

Date: _____

Follow-up needed for ☐ Cleaning ☐ X-rays ☐ Treatment

DENTIST NAME & SIGNATURE & DATE