Child Care Enrollment Form

Sieda Community Action Child Development Center

sieda COMMUNITY ACTION

Date: _____

Child Information

First Name	Middle Name	Legal Last Name

Male☐ Female☐ Date of Birth _____/_____/_____ Age ____ Verification Source _____

Birthplace: City_____ State _____ Country _____

Race (choose any that apply)

Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐
White ☐ Unspecified ☐ Other ☐ If other, please specify below.

_____

Ethnicity (as reported)

Hispanic/Latino Yes ☐ No ☐

Family Information

Parent/Guardian Name:_____ SSN:_____

Address:_____ City/Zip:_____

Cell Phone:_____ Email Address:_____

Race (choose any that apply)	Ethnicity (as reported)
Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Unspecified ☐ Other ☐ If other, please specify below. _____	Hispanic/Latino Yes ☐ No

Preferred Method of Communication Email ☐ Phone ☐ Text ☐

Parent/Guardian Name:_____ SSN:_____

Address:_____ City/Zip:_____

Cell Phone:_____ Email Address:_____

Race (choose any that apply)	Ethnicity (as reported)
Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Unspecified ☐ Other ☐ If other, please specify below. _____	Hispanic/Latino Yes ☐ No ☐

Preferred Method of Communication Email ☐ Phone ☐ Text ☐

Family Language

Primary Language	English Proficiency
English ☐ Spanish ☐ French ☐ Marshallese/Ebon ☐ Other ☐ If other, please specify below. _____	None ☐ Some ☐ Moderate ☐ Proficient ☐

Child Health	
Does the child have:	**If yes, please provide more details.**
Disability Yes ☐ No ☐	Suspected ☐ Referred ☐ Diagnosed ☐ If diagnosed, by whom and what is the disability? _____
IP and IEP Yes ☐ No ☐	
Receiving mental health services Yes ☐ No ☐	
Allergies (food, medicine, other) Yes ☐ No ☐	
EpiPen necessary Yes ☐ No ☐	
Asthma Reactive Airway Disease Yes ☐ No ☐	
Dental Braces/retainer Yes ☐ No ☐	
Diabetes Yes ☐ No ☐	
Fainting episodes Yes ☐ No ☐	
Glasses/contacts/vision concerns Yes ☐ No ☐	
Hearing aid/hearing concerns Yes ☐ No ☐	
Heart condition Yes ☐ No ☐	
Intestinal or stomach concerns Yes ☐ No ☐	
Medications given at home or daycare Yes ☐ No ☐	
Migraines/headaches Yes ☐ No ☐	
Orthopedic devices Yes ☐ No ☐	
Previous surgeries Yes ☐ No ☐	
ADD/ADHD Yes ☐ No ☐	
Scoliosis Yes ☐ No ☐	
Seizure disorder Yes ☐ No ☐	
Serious accidents Yes ☐ No ☐	
Skin problems Yes ☐ No ☐	
Sleeping concerns Yes ☐ No ☐	
Speech problems Yes ☐ No ☐	
Weight concerns Yes ☐ No ☐	
Other concerns Yes ☐ No ☐	
Physical activity limitations Yes ☐ No ☐	

Emergency Contacts and Pick Up Besides the guardians listed above, only the persons listed below are authorized to pick up your child (any changes must be made in writing)			
Name	**Relationship to Child**	**Phone**	**Address**

_____Initial here to verify the information is true. My signature on this form or my verbal consent certifies, under penalty of law, the following:

- All information and documentation are accurate and complete to the best of my ability.
- I declare I am the only person in the household who has or will apply for these programs.
- I understand that any willful misrepresentation of the information provided is subject to program disqualification and penalty of law.
- I understand my signature on this application or my verbal consent gives permission to Sieda Community Action to determine eligibility for this program and for other programs administered by the agency. I may refuse any programs or services for which I am referred.

More information may be requested as needed.

The first 30 days of a child's enrollment is a trial period for both the parents and the center. During the 30-day trial, the parent or the provider can terminate the childcare contract without notice. No childcare payments are reimbursed in the event of termination.

A minimum weekly payment is required for all children.

Minimum charges are in effect each week for the duration of this agreement (52 weeks per year). Sieda Community Action and its Child Development Center are closed:

New Year's Day • Martin Luther King Day • President's Day • Memorial Day • Juneteenth • Independence Day • Labor Day • Veteran's Day • Thanksgiving Day • Friday after Thanksgiving Day • Christmas Eve Day • Christmas Day • New Year's Eve Day • When a holiday falls on a Saturday, the Friday preceding will be observed as the holiday. When a holiday falls on a Sunday, the Monday following the calendar holiday will be observed as the work holiday.

Full week fees are due for weeks containing a holiday.

Late pickup fees are $10.00 for every 5 minutes after 5:30 P.M. and are added to the next billing statement.
By signing below, I am stating that I understand and agree to the terms of the above. I agree to pay for all fees associated with my child's attendance at the center and abide by all policies included in the family handbook.

Parent/Guardian Signature Date

Contracts are in effect until changed or official notice has been given by the family of their last day at the center.

Service Policy: It is the policy of Sieda Community Action not to discriminate on the basis of race, creed, color, national origin, religion, sex, age, disability, political party affiliation, pregnancy, military membership, veteran status, sexual orientation, gender identity status in determining eligibility or delivering services to clients or potential clients. Not all prohibition bases apply to all programs. Program eligibility criteria will be provided when requested.

Sieda Community Action is an equal opportunity employer.