

Springs of Life Children's Center
ENROLLMENT PACKET
2018





Dear Parent,

Thank you for considering Springs of Life Children's Center (SLCC) for your childcare needs! We are committed to providing quality care in a loving environment. Our staff is trained to encourage each child to reach his or her potential in areas of physical, emotional, social, intellectual and spiritual growth.

Please take the time to read through our Parent Handbook to make sure that SLCC is a good fit for you and your child(ren). **All of the information requested in the enrollment packet is required by state FYI Ujcb, and must be submitted prior to your child(ren) starting.** Please make sure that all of the information is filled out correctly. If you have any questions or concerns, one of our staff members would be happy to help you. You are also welcome to visit the center and to meet with a staff person prior to filling out any paperwork. Our desire is that you, as a parent, feel comfortable with SLCC prior to your child's enrollment.

After you've completed the Enrollment Packet, please turn it in to a staff member along with the Enrollment Fee (\$20 for one child and \$10 for each additional child - CCAP pays this for families with CCAP assistance).

We look forward to serving your family! May God Bless you on your journey in Parenting!

Dan Finnegan
Board President
Springs of Life Children's Center

**SPRINGS OF LIFE CHILDREN'S CENTER FAMILY
INFORMATION REGISTRATION FORM**

FAMILY INFORMATION

Child's First, M.I. and Last Name	Name Called By	Gender	Age	Date of Birth	Desired Start Date

Guardian #1

First, M.I. and Last	Relationship	Date of Birth	E-Mail Address	
Home Address		City/ State	Zip Code	Phone Number
Place of Employment		Work Phone #	Business Address	

Guardian #2

First, M.I. and Last	Relationship	Date of Birth	E-Mail Address	
Home Address		City/ State	Zip Code	Phone Number
Place of Employment		Work Phone #	Business Address	

Guardian #3

First, M.I. and Last	Relationship	Date of Birth	E-Mail Address	
Home Address		City/ State	Zip Code	Phone Number
Place of Employment		Work Phone #	Business Address	

Emergency Contact	Relationship	Primary Phone #	Address (including zip code)
*			
*			

*At least two emergency contacts with valid phone numbers and address are **required by state regulations**

Persons <i>NOT</i> allowed to pick-up my child(ren)	Reason**

If any reason listed involves a divorce/incident that resulted in sole custody and/or restraining order, a copy of the court order **must be on file at all times.

SPRINGS OF LIFE CHILDREN'S CENTER
MEDICAL CONSENT FORM ALL FIELDS ARE REQUIRED (do not leave
blank - write "n/a")

Child #1 Name	Special Diet*	
Allergies*	Medical Conditions**	Medication**

Child #2 Name	Special Diet*	
Allergies*	Medical Conditions**	Medication**

Child #3 Name	Special Diet*	
Allergies*	Medical Conditions**	Medication**

Child #4 Name	Special Diet*	
Allergies*	Medical Conditions**	Medication**

* Any food allergies that require a change in menu need to be documented and signed by a licensed medical practitioner using the *Special Diet Statement* form.

Any, and all, special needs and/or medical conditions need to be reviewed by the SLCC board to evaluate whether specialized care can be accommodated. SLCC follows all State Rules & Regulations regarding anti-discriminatory laws

** All medical conditions need to be documented and signed by a licensed medical practitioner using the *Specialized Child Care Plan* form.

Please read and sign the following statement:

I hereby certify that all the information provided on this page is accurate and complete. I further state that my child has no other medical issues, special diet accommodations, allergies, or mental disorders, aside from the ones listed above.

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

Name of Professional	Emergency Phone Number	Business Address
Doctor:		
Dentist:		
Hospital:		
Insurance:		

State regulations require that you list a doctor, dentist, and hospital, all with a phone number and address

Consent for Medical Care & Treatment

Please read carefully and **initial each of the following statements.**

I hereby give my permission for SLCC staff & medical personnel to care for my child(ren) in the event of an emergency. _____ I give my permission for my child(ren) to be transported by ambulance, helicopter or aide care in the event that I am not present and unable to be reached. _____ I waive my right of informed consent and authorize hospital care, treatment & procedures to be performed on my child(ren) at the advice of a licensed physician, healthcare provider, hospital, and/or emergency personnel in order to safeguard my child(ren)'s life(s). _____ I understand that I am responsible for any and all costs for care that may accrue due to emergency care.

Guardian's Printed Name: _____ **Dated:** _____

Guardian's Signature : _____

Springs of Life Children's Center Child Care Financial Contract

	Full Name	Social Security # (required)
Primary Payer:		-- --
Secondary Payer:		-- --

Tuition Worksheet

Classroom	Age Range	Tuition	Child Name(s)	Scholarship* / CCAP	Total Adjusted Tuition (write "copay" if CCAP)
Infants (Full-time only)	6wks-12m	\$ 275.00			
Toddler (Full-time only)	12m-2.5y	\$ 250.00			
PS1 (Full-time only)	2.5y-3.0y	\$ 240.00			
PS2 (Full-time only)	3.0y-4.0y	\$ 200.00			
PK (Full-time only)	4.0y-5.0y	\$ 200.00			
**SAP FT (>5 hours per day)	5.0y - 16.0y	\$ 190.00			
**SAP PT (<5 hours per day)	5.0y-16.0y	\$ 100.00			
**SAP FT Drop-in (>5 hrs)	5.0y - 16.0y	\$ 55.00			
**SAP PT Drop-in (<5 hrs)	5.0y-16.0y	\$ 35.00			
Total tuition (write copay if CCAP) =					

*Any family is welcome to apply for a scholarship provided by Springs of Life Church. Please speak with the Enrollment Specialist if you are interested in applying.

**All School-age program rates include transportation: the weekly transportation rate is \$20 for both FT and PT programs. The daily transportation rate is \$5 per day.

**Full-time days (child attends >5 hours on school closure days for holidays/weather) are a \$30 per day upcharge on top of part-time tuition.

Fee Schedule (in addition to weekly tuition and monthly co-pays)

Enrollment Fee	\$20 for 1st child, \$10 for each additional child
Check Resubmission Fee	\$10/incident
Returned Check Fee	\$25/incident
Late Payment Charge	\$10/incident
Late Pick-up Charge	see late pick-up form for details
Over 10 hours daily care	TBD by director/Finance Department on case-by-case basis

Signed Payment Agreement

<p>I, _____, understand that upon signing this form I enter into a binding contract with Springs of Life Children's Center. I agree to pay the charge of _____ every _____, in addition to any other charges or fees I incur on my account. I agree to give SLCC two-weeks written and paid notice if I decide to end my contract with SLCC for any reason, whether I decide to have my child(ren) in the center for those two weeks or not.</p>
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<div style="display: flex; justify-content: space-between;"> <div>Primary Payer Signature: _____</div> <div>Date: _____</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div>Secondary Payer Signature: _____</div> <div>Date: _____</div> </div>

**SPRINGS OF LIFE CHILDREN'S CENTER
CHILD BEHAVIOR HISTORY FORM**

SLCC believes each child is capable of making positive behavior choices and changes when necessary. As stated in the Discipline section of your Parent Handbook, SLCC takes a team approach in the child behavior modification process, calling on the help of both SLCC Staff and the child's Parents to curb unwanted behavior.

Please take this time to inform us of all previous/current discipline or behavior issues your child has. No child's admittance to SLCC will be determined by this disclosure. SLCC desires to take a proactive approach to behavior needs from the first day of your child's enrollment. By completing this form, you will equip us to better serve both you and your child.

Child(ren)'s Name(s): _____

ATTITUDE

- ☐ Blatant Disobedience
- ☐ Excessive Crying or Whining
- ☐ Tantrum-throwing or Fits
- ☐ Other: _____

LANGUAGE

- ☐ Mocking or Teasing Other Children
- ☐ Name-calling
- ☐ Swearing
- ☐ Talking Back to Someone in Authority
- ☐ Other: _____

PHYSICAL

- ☐ Biting
- ☐ Hitting or Punching
- ☐ Inappropriate Touching or Exposure
- ☐ Kicking
- ☐ Pulling Hair
- ☐ Ruining or Defacing Property
- ☐ Other: _____

What steps have been taken to end the unwanted behavior(s)?

Comments:

Read and sign the following statement:.

I certify that the information provided on this page is accurate and complete. I further acknowledge that my child has no other major behavioral issues, others than those listed here. I understand non-disclosure of such behavior concerns would be grounds for immediate termination of care with Springs of Life Children's Center.

Parent's Signature: _____ Date: _____

Director's Signature: _____ Date: _____

Table 1. MINIMUM NUMBER OF DOSES REQUIRED FOR CERTIFICATE OF IMMUNIZATION

[illegible]

a: Vaccine doses administered ≤ 4 days before the minimum interval or age are to be counted as valid

b: Five doses of pertussis, tetanus, and diphtheria vaccines are required at school entry in Colorado unless the 4th dose was given at ≥ 48 months (i.e., on or after the 4th birthday) in which case only 4 doses are required

c: For students ≥ 7 years who have not had the required number of pertussis doses, no new or additional doses are required. Any student ≥ 7 years at school entry in Colorado who has not completed a primary series of 3 appropriately spaced doses of tetanus and diphtheria vaccine may be certified after the 3rd dose of tetanus and diphtheria vaccine (or tetanus, diphtheria, and pertussis vaccine if 10 or 11 years) if it is given > 6 months after the 2nd dose.

d: The student must meet the minimum prior requirement for the 4th or 5th doses of diphtheria, tetanus, and pertussis vaccine and have 1 tetanus, diphtheria, and pertussis vaccine dose.

e: For polio, in lieu of immunization, written evidence of a laboratory test showing immunity is acceptable.

f: Four doses of polio vaccine are required at school entry in Colorado unless the 3rd dose was given ≥ 48 months (i.e. on or after the 4th

birthday) in which case only 3 doses are required. Four valid doses are a complete series regardless of age at completion.

g: For measles, mumps, and rubella, in lieu of immunization, written evidence of a laboratory test showing immunity is acceptable for the specific disease tested. The 1st dose of measles, mumps, and rubella vaccine must have been administered at ≥ 12 months of age (i.e., on or after the 1st birthday) to be acceptable.

h: The 2nd dose of measles vaccine or measles, mumps, and rubella vaccine must have been administered at least 28 calendar days after the 1st dose.

i: Measles, mumps, and rubella vaccine is not required for college students born before January 1, 1957.

J: The number of Hib vaccine doses required depends on the student's current age and the age when the vaccine was administered. If any dose was given ≥ 15 months, the Hib vaccine requirement is met. For students who began the series < 12 months, 3 doses are required of which at least 1 dose must have been administered at ≥ 12 months (i.e., on or after the 1st birthday). If the 1st dose was given at 12 to 14 months, 2 doses

are required. If the current age is ≥ 5 years, no new or additional doses are required.

k: The number of pneumococcal conjugate vaccine doses depends on the student's current age and the age when the 1st dose was administered. If the 1st dose was administered at:

- (i) ≤ 6 months, 3 doses are required at 6 to 14 months and 4 doses are required at 15 to 23 months with 1 dose administered on or after the 1st birthday;
- (ii) 7 to 11 months, 2 doses are required at 6 to 14 months and 3 doses are required at 15 to 23 months with 1 dose on or after the 1st birthday;
- (iii) 12 to 23 months, 2 doses are required. If the current age is ≥ 2 years, no new or additional doses are required.

I: For hepatitis B, in lieu of immunization, written evidence of a laboratory test showing immunity is acceptable. The second dose should be administered at least 4 weeks after the first dose, and the third dose should be administered at least 16 weeks after the first dose and at least 8 weeks after the second dose. The final dose is to be administered at 24 weeks of age (6 months of age) and is not to be administered prior to that age.

m: For varicella, written evidence of a laboratory test showing immunity or a documented disease

history from a health care provider is acceptable. The 1st dose of varicella vaccine must have been administered at ≥ 12 months of age (i.e., on or after the 1st birthday) to be acceptable.

n: If the second dose of varicella vaccine was administered to a child <13 years, the minimum interval between dose 1 and dose 2 is 3 months, however, if the second dose is administered at least 28 days following the first dose, the second dose does not need to be repeated. For a child who is ≥13 years, the second dose of varicella vaccine must have been administered at least 28 calendar days after the 1st dose. See Table 2 for the school years/grade levels that the 1st and 2nd doses of varicella will be required.

o: If the 1st dose of varicella vaccine was administered at ≥ 13 years, 2 doses are required, separated by a minimum of 4 to 8 weeks.

p: Information concerning meningococcal disease and the meningococcal vaccine shall be provided to each new student or if the student is under 18 years, to the student's parent or guardian. If the student does not obtain a vaccine, a signature must be obtained from the student or if the student is under 18 years, the student's parent or guardian indicating that the information was reviewed

**Table 2. TIMETABLE FOR IMPLEMENTATION OF REQUIREMENTS FOR
SELECTED IMMUNIZATIONS FOR GRADES K TO 12**

Refer to Table 1 for the minimum number of doses required for a particular grade level. Table 2 shows the year of implementation for a requirement from Table 1 and is restricted to varicella vaccine dose 1 (Var1) and dose 2 (Var2) and tetanus, diphtheria, and pertussis vaccine (Tdap). Requirements and effective dates for other vaccines are listed in Table 1. In this table, after a vaccine is required for grades K to 12, it is no longer shown, but the requirements listed in Table 1 continue to apply.

[illegible]

Child and Adult Care Food Program 2017-2018 Child Care Income Eligibility Form Letter

Dear Parent or Guardian,

Congratulations! You have chosen a childcare provider that participates in the Child and Adult Care Food Program (CACFP). Participating in the CACFP means that the provider cares about good nutrition for children, will introduce and serve a variety of nutritious foods for your child to eat, and will serve foods appropriate for your child's nutritional needs. The provider you have chosen cannot charge a separate fee for meals, nor ask you to provide food for your child for meals claimed for reimbursement from the CACFP, except in some special cases. Depending upon the hours in care, your provider will be serving your child breakfast, morning snack, lunch, afternoon snack, supper, and/or late snack.

Please complete, sign, and return this **Income Eligibility Form (IEF)** to the center as soon as possible. This information is required for the center to receive CACFP reimbursement for the meals served to your child. The Colorado Department of Public Health and Environment assures that **this form is confidential** and the information you provide will not be used elsewhere.

If no person in your household receives benefits from Temporary Assistance For Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), also known as Food Stamps, or the Food Distribution Program on Indian Reservations (FDPIR), or is not the beneficiary of the Other Source Categorical Eligibility programs, please list your household's total gross income from the current month, the amount projected for the first month the application is made for, or the month prior to the application. The U.S. Department of Agriculture, which funds the CACFP, defines a household as a group of related or unrelated individuals who are living as one economic unit and who share housing and all significant income and expenses.

If no person in your household receives benefits from Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), or the Food Distribution Program on Indian Reservations (FDPIR), you must provide the last four digits of your Social Security Number according to regulations. The disclosure of the Social Security Number is voluntary; however, the last four digits of the Social Security Number, or an indication of "none," is required for the approval of this form.

If any of the children living in the household are beneficiaries of the Other Source Categorical Eligible programs (Foster, Head Start/Early Head Start or Even Start Program, Homeless, Migrant or Runaway), the children are eligible for free meals and there is no need to complete an application - just mark the box next to the program that applies. The institution collecting the form will need to verify the child's participation in the program by requesting documentation from the placement office if the child is a foster child, from the Even Start or Head Start official if the child or the pregnant mother is enrolled Head Start or Early Head Start or the child is an Event Start participant, and from the Migrant, Homeless or Runaway program officials, if the child is a migrant, homeless or runaway child. For Even Start, documentation from the Even Start official confirming that the child has not yet entered Kindergarten.

If any person in your household receives benefits from the Temporary Assistance For Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), or the Food Distribution Program on Indian Reservations (FDPIR), income reporting in Part 3 and the disclosure of the last four digits of the Social Security Number (SSN) in Part 4 are not required.

Household Income Chart

If your household's income is less than or the same as the amounts indicated for your household's size on the chart below, the center will receive more meal reimbursement from the Child and Adult Care Food Program (CACFP) to help provide the best meals possible for the children in care.

Household Size	1	2	3	4	5	6	7	8	For each additional person add:
Yearly	22,311	30,044	37,777	45,510	53,243	60,976	68,709	76,442	+ 7,733
Monthly	1,860	2,504	3,149	3,793	4,437	5,082	5,726	6,371	+ 645
Weekly	430	578	727	876	1,024	1,173	1,322	1,471	+149

This chart is not to be used for determining eligibility by center staff, but is a guide for families completing the form.

CACFP REQUIRED MEAL ITEMS				
MEALS	COMPONENTS	AGE 1-2	AGE 3-5	AGE 6-12
Breakfast	Fluid Milk	½ cup	¾ cup	1 cup
	Juice or Fruit or Vegetable	¼ cup	½ cup	½ cup
	Bread or Bread Alternate	½ slice	½ slice	1 slice
Snack	Fluid Milk	½ cup	½ cup	1 cup
	Juice or Fruit or Vegetable	½ cup	½ cup	¾ cup
	Meat or Meat Alternate	½ ounce	½ ounce	1 ounce
	Bread or Bread Alternate	½ slice	½ slice	1 slice
Lunch Supper	Fluid Milk	½ cup	¾ cup	1 cup
	Fruit or Vegetable or Juice (Must serve at least 2 different varieties)	¼ cup total	½ cup total	¾ cup total
	Bread or Bread Alternate	½ slice	½ slice	1 slice
	Meat or Poultry or Fish	1 ounce	1½ ounces	2 ounces
	Cheese or	1 ounce	1½ ounces	2 ounces
	Egg or	½	¾	1
	Cooked Dry Beans and Peas or	¼ cup	¾ cup	½ cup
	Peanut Butter or	2 Tbsp	3 Tbsp	4 Tbsp
	Yogurt, Plain or Flavored (May also be served at snack)	4 ounces	6 ounces	8 ounces
		or ½ cup	or ¾ cup	or 1 cup

SAMPLE MENU	
BREAKFAST	<ul style="list-style-type: none"> ◆ Oatmeal ◆ Baked Apples & Raisins ◆ Milk
SNACK	<ul style="list-style-type: none"> ◆ Hard Cooked Egg ◆ Carrot Sticks
LUNCH/SUPPER	<ul style="list-style-type: none"> ◆ Turkey and Cheese Tortilla Roll ups ◆ Orange Slices ◆ Sliced Tomatoes ◆ Milk

If you have questions about the CACFP, contact your childcare provider's CACFP Sponsor.

Name of CACFP Sponsor: _____

Phone Number: _____

If the center is not a sponsored facility, contact:
Child and Adult Care Food Program
Colorado Department of Public Health and Environment
303- 692-2330.



Here are the next steps now that you have turned in an enrollment packet (these must be done before your first day):

1. Turn in any missing/incomplete paperwork:
 - a. _____
 - b. _____
 - c. _____
 - d. _____
2. Get CCAP authorization on our CCAP provider ID # (if applicable)
3. Schedule and complete an orientation
4. Set a start date with the Enrollment Team
5. Arrive on your scheduled start date with your first day supplies

Thank you for enrolling your child at Spirings of Life! We are blessed to have the opportunity to serve you and your family.